

Central Manchester University Hospitals NHS Foundation Trust

Manchester Royal Infirmary

Quality Report

Oxford Rd
Manchester
M13 9WL
Tel: 0161 2761234
Website: www.cmft.nhs.uk

Date of inspection visit: 3 – 6 November 2015 and 26
November 2015
Date of publication: 13/06/2016

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

Ratings

Overall rating for this hospital

Good



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Good



Surgery

Good



Critical care

Good



Maternity and gynaecology

Good



Neonatal services

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Manchester Royal Infirmary is a large teaching hospital that is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital provides a full range of general and specialist services including emergency care, critical care, general medicine including elderly care, surgery and outpatient services. The hospital is also a specialist regional centre for kidney and pancreas transplants, haematology and sickle cell disease. The Heart Centre is a major provider of cardiac services in the region, specialising in cardiothoracic surgery and cardiology. Located on the same site as the Manchester Royal Infirmary are the following specialist hospitals:

St Mary's Hospital - a specialist hospital for women, babies and families

Royal Manchester Children's Hospital (RMCH) - provides specialist healthcare services for children and young people. With 371 beds it is the largest single-site children's hospital in the UK.

Manchester Royal Eye Hospital (MREH) - a large, specialist ophthalmic teaching hospital.

Each hospital is based on the trust's main site along with the Manchester Royal Infirmary (MRI) but is a separate, purpose-built building with its own identity as a specialist hospital.

We carried out this inspection as part of our comprehensive inspection programme. We carried out an announced inspection of Manchester Royal Infirmary, Royal Manchester Children's Hospital, St Mary's Hospital and the Manchester Royal Eye Hospital between 3 and 6 November 2015. In addition an unannounced inspection was carried out between 3pm and 8pm on 23 November 2015 at Manchester Royal Infirmary, St Mary's Hospital and Royal Manchester Children's Hospital. As part of the unannounced visit we looked at triage and safeguarding processes in accident and emergency services and staffing levels in maternity services. We have reported our findings for all four hospitals within this report.

Overall we rated Manchester Royal Infirmary as 'Good'. We have judged the service as 'good' for safe, caring, effective and well-led care and noted some outstanding practice and innovation. However improvements were needed to ensure that services were responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The areas we inspected were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene, 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Nurse and midwifery staffing

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services.
- However nurse staffing levels, although improved, remained a challenge. There were still a high number of nursing vacancies across most services including midwifery, general medicine, A&E and surgery. The trust was actively recruiting nursing staff from overseas to try and improve staffing levels.
- Although we found staffing levels were adequate at the time of our inspection, there was no flexibility in numbers to cope with increased demand, or short notice sickness and absence.

Summary of findings

- St Mary's Hospital had implemented a number of initiatives to continually assess patient acuity and staffing levels using a designated co-ordinator. There was a commitment to increase the number of midwives available and recruitment was ongoing.
- Services tried to use the same bank and agency staff to ensure they had the required skills to work on the ward. Agency staff were given an induction before commencing work.
- The Intensive Care Society standard for nurse staffing states there should be a band 6 or 7 supernumerary clinical coordinator on duty 24 hours a day, seven days a week. At the time of inspection this was not always happening on the cardiac intensive care unit as there was not a supernumerary clinical coordinator on duty during the night shift. We were told of occasions when this supernumerary provision was met but a staff member may then be moved during the night to assist other areas within the hospital. We raised this matter with the directorate senior staff at the time of inspection. They responded promptly by immediately implementing an action plan which gave the cardiac intensive care unit their supernumerary clinical coordinator at night.
- Data showed there had been a 33% increase in the demand for end of life care services. The need for sufficient specialist palliative care staff to meet the demand for the service had been identified by the service and was on the end of life risk register. A business case had been submitted to seek investment in services to enable staff to respond in a timely manner and provide access seven days a week and out of hours.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- There were sufficient numbers of consultants and medical staff to provide patients with safe care and treatment.
- Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- There was 168 hours of consultant presence on Maternity and NICU. The trust was one of only two in the country to implement this standard.
- For patients with palliative/end of life care needs, medical cover was provided on the general wards in MRI.
- Palliative care consultant cover was below the recommended staffing levels outlined by the Association for Palliative Medicine of Great Britain and Ireland and the National Council for Palliative Care guidance.

Access and flow

- Due to the number of emergency admissions and increased demand for services there was continual pressure on the availability of beds across the hospitals, particularly the MRI and RMCH. As a result the management of patient access and flow across the hospitals remained a significant challenge for managers. There were sound arrangements to ensure the timely medical review of patients.
- The trust's performance for patients being seen within 4 hours was similar to the England average and the trust exceeded the 95% target between March and May 2015. However, the adult emergency department at MRI consistently failed to meet national targets for time to treatment, time to discharge and ambulance handovers.
- Both the adult's and children's departments were often overcrowded. At the time of our visit, the children's emergency department reached full capacity and we saw the matron and the clinical lead contact operational managers across the hospital to increase the flow of patients. Records showed that between April and September 2015, 15% of patients waiting in the adult emergency department to be admitted to the MRI were waiting on a trolley for between four and 12 hours. This was worse than the England average of around 2%.
- In MRI and RMCH, patients were sometimes placed on wards that were not best suited to meet their needs (also known as outliers). However, there were good systems in place for the management of these patients to ensure they received a regular medical review.
- The hospital held bed management meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures.

Summary of findings

- There was a clear focus on discharge planning although there were a number of patients experiencing delayed discharge because they were waiting for packages of care.
- Adult surgery services achieved the 18 week referral to treatment standards across all specialties. Elective operations were frequently cancelled due to a lack of available beds and theatre lists running late. The rate of cancelled elective operations had been higher than the England average since July 2014. However, the division of surgery transformation plan included actions to improve theatre efficiency and reduce cancelled operations.
- At RMCH surgery services faced ongoing challenges in meeting the 18 week referral to treatment time standards, with some specialist services experiencing waiting list pressures.
- There had been significant improvements in adult critical care services in reducing the number of patients discharged out of hours. However, challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Similarly capacity issues in the cardiac intensive care unit (and wider cardiac wards) meant beds were not always available to allow patients to be discharged onto a ward.
- Bed occupancy rates in maternity services were 25% higher than the England average throughout April, May and June 2015. This meant there was insufficient capacity for the numbers of patients attending the maternity unit. A policy to divert patients to other units in the area was in place however, the threshold for the use of this policy was not clearly defined and there was no risk assessment to support the process.
- The system at St Mary's Hospital was to plan eight inductions per day, however due to bed capacity and staffing, these were often not completed on the day. This led to some patients being admitted to wait for induction and others being sent home to wait.

Mortality rates

- Mortality and morbidity meetings were held monthly and were attended by representatives from all teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for every patient who had died in the hospital within the previous week. Any learning identified was shared and applied.
- The trust had previously been identified as an outlier for puerperal sepsis and other infections as part of the CQC intelligent monitoring programme. On request, the trust had provided the CQC's maternity outliers panel with the requested information and could evidence that a full investigation had taken place to understand the data and identify areas for improvement. As a result the service had an action plan in place and this had reduced the rate of infection from 6.8% to 4% between April 2015 and July 2015.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and the speech and language therapy team.
- A coloured tray and jug system was in place to highlight which patients needed assistance with eating and drinking.
- Some wards had 'protected mealtimes' in place when all other activities on the wards stopped, if it was safe for them to do so. This meant staff were available to help serve food and assist those patients who needed help.
- The food and drink provision had been reviewed since the last inspection in 2013, which highlighted that the choice of food across the hospital was limited. As a result, actions had been taken to improve food provision. Work however, across the trust was ongoing. The standard of food was an identified risk on the trust's risk register and a programme of work was being undertaken to understand where and what improvements were required.

We saw several areas of outstanding practice including:

- Staff monitored patients by using an electronic early warning score system that automatically notified medical staff and some non-medical staff (such as the surgical lead pharmacist) if there was deterioration in a patient's medical condition. This process was fully embedded across the main site and all the staff we spoke with were positive about using this system.

Summary of findings

- The diagnostic imaging department used innovative new technology for assessing coronary artery disease which was available in only two centres in the UK. This meant that patients only required a single one hour visit rather than two visits and three hour appointments. It also meant lower radiation doses were administered to both staff and patient when compared with conventional technology.
- The neonatal unit used video technology to support women who were not well enough to visit their baby, and a bleep system for parents so that they were involved when decisions were being made by medical teams.
- The gynaecology emergency unit was locally unique in that it allowed patients to refer themselves to a specific unit for assessment and treatment of gynaecological emergencies and problems in early pregnancy.
- The development of a nationally unique service relating to developmental sexual dysfunction. This specialist clinic met the very specific needs of patients suffering a variety of sexual development issues. Patients who attended this clinic had the opportunity to be seen by consultant gynaecologists, endocrinologists and psychologists. Counselling services specific to the patients who attended the clinic was also available.
- Staff at St Mary's hospital participated in an extensive programme of local, national and internationally recognised research. In areas such as female genital mutilation (FGM), senior staff within St Marys were participating in the development and implementation of national guidelines.
- The adult rheumatology ward had really thought about the feelings of young people transitioning into their department. They considered how young people would feel sitting in waiting rooms predominately designed for older patients and had developed a separate young person clinic, which was due to start in January 2016. They had involved young people in the re-design of the waiting room, using a mural of photographs of the young patients. The ward had set up a youth group who communicated via social media, which the staff monitored. They had developed their own education sessions for young people, in particular a session called 'Sex, drugs, rock and roll', to inform the young people of their condition and the impact of their life style choices.
- The baby hip clinic was the first example of a one stop assessment and treatment service for children with developmental dysplasia of the hip to be a collaboration between all consultants, rotating through the clinic, with agreed protocols and pathways, allowing standardisation of care and facilitating audit and research. This innovation placed the clinical needs of children and ease of accessing assessment and treatment for parents at the forefront of service redesign.
- Trained nurses were able to undertake eye screening for retinopathy of prematurity (ROP) using a web cam for babies in the neo-natal unit and were able to get immediate clinical review by ophthalmology consultants. The service had been evaluated as successful and was provided in other units as a result.
- The MREH was identified as a NICE exemplar (best practice) service for the management of glaucoma.

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

Importantly, the trust must:

- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed in all services, particularly urgent and emergency services, medical care, surgery services and end of life care. This also includes midwives in all areas of the maternity services and sufficient doctors to provide timely review of patients when requested.
- Improve patient flow through the Manchester Royal Infirmary, St Mary's Hospital and Royal Manchester Children's Hospital, particularly in maternity services, medical care, surgery services and A&E.

In addition the trust should:

- Ensure checks of resuscitation equipment are carried out and recorded in line with trust policy and procedures.
- Ensure medicine fridge temperatures are recorded daily and staff take appropriate action if and when a temperature is outside the recommended range.
- Continue to improve the quality and storage of patient records to ensure they are fully completed and all contents are securely stored.

Summary of findings

- Ensure that all staff receive appraisals and mandatory training to enable them to carry out their role and responsibilities.
- Have a vision and strategy in place for end of life care for adults, children and young people. The trust should review the leadership for palliative care across the service to ensure it reflects the needs of patients.
- The trust should ensure that appropriate systems are in place to assess, monitor and improve the quality of end of life care provision for patients and their families.

In urgent & emergency services

- Upgrade the mental health rooms as planned.
- Ensure that there are established systems in place to effectively document adult safeguarding concerns.
- Ensure the risk register is regularly updated and clearly reflects actions taken to control and mitigate risks.
- Consider how to prevent or manage the spread of infection on OMU.
- Consider how side rooms without nurse call bells are used in ED.
- Consider how to make services in the WIC more child friendly.
- Ensure staff in the children's emergency department hand hygiene protocols to prevent the spread of infections.
- Review safeguarding processes for triaging a patient and the electronic patient record system to ensure that every opportunity is taken to identify and make staff aware of safeguarding or child protection concerns when a child or young person presents at the children's emergency department or walk in centre.

In medical care services

- Consider the review of training around the medicines policy in relation to the administration of patients own medication and the administration of when required medication.
- Ensure that all staff understand and follow the correct process when completing DoLS applications.
- Ensure that all equipment has up to date electrical safety certificates and that oxygen cylinders are stored in line with guidelines.
- Ensure that patients' privacy and dignity is maintained at all times on the endoscopy unit.
- Ensure that all staff seek consent for the use of bedrails and if patients lack capacity apply the Mental Capacity Act (2005) principles.

In surgery services

- Improve availability of patient notes for patients admitted as part of the rapid access process.

In critical care services

- Should review the medical staffing model operated in the paediatric high dependency unit (PHDU) to ensure that it fully supports effective care for children on the unit.
- Should ensure there is a clear vision and strategic plan in place for the cardiac intensive care unit.

In maternity and gynaecology services

- Ensure that all areas of the maternity services are clean and tidy at all times.
- Ensure that personal protective clothing used in the operating theatres meets with current guidance.
- Ensure there is adequate seating made available for patients to wait in comfort in the day assessment unit and the maternity triage area.
- Ensure their policy and procedures for the induction of labour meet with current guidance.
- Take action to ensure that there is a robust system for protecting babies from abduction.

In children and young people's services

Summary of findings

- Ensure there is a clear policy in place for transition services based on current guidelines and relevant legislation that considers how services can work in a joined up way to provide a person centred approach across children and adult services.
- Ensure medicines are labelled with the date they are opened so that they are disposed of in a timely manner.
- Consider having a designated isolation area, for patients that enter the children's emergency department with infectious diseases.
- Consider how blood sample tubes can be transported from ward 85 to the pathology laboratory in a timely manner.
- Continue to work with children, young people and their families to ensure that food and menu options are child friendly and appeal to patients using the service.

In end of life care services

- Ensure staff have access to suitable and sufficient equipment, such as syringe drivers to deliver person centred care in a safe and effective way to meet people's needs.
- Review its access to specialist palliative care over 24 hours (seven days) in line with national guidance for end of life care.
- Ensure that it fully implements the national recommendations following the removal of the Liverpool Care Pathway.
- Reduce the frequency of delays above 60 minutes for patients attending appointments.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We rated urgent and emergency services as 'Requires improvement' overall because;

In the adult ED, registered nursing and care staff shifts were regularly unfilled in the emergency department. Daily checks of essential equipment were not always completed. The high risk mental health assessment room did not ensure the safety of staff. Systems to safeguard patients were not always reliable and documentation of safeguarding was not consistent.

In the children's ED, improvements in infection control and cleanliness standards were required. Medicines were not always checked regularly or labelled appropriately with the date they were first opened. Records were not always stored securely. The processes to highlight previous or ongoing safeguarding or child protection concerns were not robust. Nurse staffing numbers in the clinical decision unit (CDU) were lower than the required levels on some occasions.

The trust's performance for patients being seen within 4 hours was similar to the England average and the trust exceeded the 95% target between March and May 2015. However, the adult emergency department at MRI consistently failed to meet national targets for time to treatment, time to discharge and ambulance handovers. Around 40% of ambulance handovers had a turnaround time of over 30 minutes between June 2014 and May 2015. In the year from August 2014 to July 2015 there were a total of 860 black breaches across the trust (black breaches are when the time between ambulance arrival and handover of the patient to ED is over 60 minutes). Both the adult's and children's departments were often overcrowded. However; care and treatment was provided in line with national guidance. The services participated in local and national audits to benchmark their practice and performance and to improve patient care. Patient outcomes were positive and staff were supported to develop their skills and knowledge to achieve these outcomes. Pain relief was provided in a timely manner. There was good multi-disciplinary

Summary of findings

working and good communication between teams. Patients were treated with dignity and respect. They were involved in their care and treatment and supported to make decisions. Patients and their families were offered emotional support and staff acted with care and compassion. Their privacy and confidentiality was respected at all times. There were clear governance systems in place. There was an open, honest culture with a drive to improve quality. Staff felt supported by leaders and that the senior management team were visible. Departmental risks were recognised and the lessons learnt from incidents and complaints were shared. Research and quality improvement were embedded within the services.

Medical care (including older people's care)

Good



We rated medical care services as 'Good' overall because;

Care was provided in line with national best practice guidelines and medical care services participated in the majority of clinical audits where they were eligible to take part. National audits indicated that the majority of patients experienced good outcomes. Improvements had been made in the provision of stroke care although some improvements were still required. Action plans were in progress where areas for improvement had been identified. There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this. Incidents were reported and investigated appropriately. Lessons were learnt and improvements made following incidents and findings were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices. Staff understood the key principles around obtaining informed consent, the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). However DoLS paperwork could be variable, particularly in relation to emergency applications.

Medical services met the 18 week standards for referral to treatment times in all specialities from September 2013 to July 2015. Patients were sometimes placed on wards that were not best

Summary of findings

suited to meet their needs (also known as outliers). However, there were good systems in place for the management of these patients to ensure they received a regular medical review. Services took into account the needs of the local people. The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not scheme for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. There was access to translation services and leaflets were available for patients about the services and the care they were receiving. There were governance systems in place which included a risk register. Some risks on the register had no actions or control measures identified so it was not clear if they were being managed effectively. It was unclear from the evidence provided if services were implementing the agreed governance framework or discussing risks at the relevant meetings. All staff knew the trust vision and values framework. Staff felt supported and morale was good. All staff were committed to delivering good quality care and were motivated to work at the hospital. However, nursing staffing levels on some of the wards did not meet the planned requirements, especially at night, on the endoscopy unit and the acute medical unit. Records were left unsecured on the wards we visited and there was a risk that personal information was available to members of the public. There were standards for record keeping that required improvement but records did include a treatment plan for each patient. There were a number of patients who were moved during the night on some wards and half of all patients experienced one or more moves during their stay. Patients' privacy and dignity was not always maintained on the endoscopy unit as there were male and female patients in hospital gowns in the same waiting room with only a temporary screen to separate them. Plans were in place to address this.

Surgery

Good



We have rated surgical services as 'Good' overall because;
There were sufficient numbers of consultants and medical staff to provide patients with safe care and

Summary of findings

treatment. There were still a high number of nursing vacancies in the wards and theatre areas at Manchester Royal Infirmary. However, staffing levels were maintained through the use of existing staff working overtime and with agency staff. There were plans in place to recruit 60 whole time equivalent nurses through EU and international recruitment by the end of January 2016. This was in addition to a planned recruitment of approximately 150 staff from the trust's domestic recruitment programme. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean and suitably maintained premises.

Surgical services provided effective care and treatment that followed national clinical guidelines and participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. 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. Patients spoke positively about their care and treatment and they were treated with dignity and compassion.

The surgical services achieved the 18 week referral to treatment standards across all specialties. There were systems in place to support vulnerable patients. However, further improvements were needed in relation to how the services provided at MRI responded to patient needs. There was insufficient bed capacity in the surgical wards which meant emergency patients were routinely transferred to the elective treatment centre short stay ward. Elective operations were frequently cancelled due to the lack of available beds and theatre lists running late. The rate of cancelled elective operations was higher than the England average since July 2014. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between October 2014 and June 2015. The division of surgery transformation plan included improvement actions to improve theatre efficiency and reduce cancelled operations. There

Summary of findings

was sufficient capacity in the MREH to ensure patients admitted for surgery could be seen promptly and receive the right level of care. The rate of operations cancelled at this hospital was low and within expected levels.

The trust vision and values had been cascaded across the surgical wards and departments and staff had a clear understanding of what these involved. The wards and theatres had clearly visible leadership with clinical, nursing and business leads. Most staff were positive about the culture and support available. Monthly clinical effectiveness meetings reviewed incidents, key risks and monitoring of performance. There was routine public and staff engagement and actions were taken to improve the services.

Critical care

Good



We rated critical care services as 'Good' overall because;

There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. There was not always a supernumerary shift coordinator on shift on the cardiac intensive care unit at night. However, we raised this with the trust and they responded immediately to this shortfall, implementing an action plan which ensured that staffing numbers on night duty met with the intensive care society standard. We found a culture where incident reporting and learning was embedded and used by staff.

The clinical areas benefited from recent refurbishment and met with the latest health building note guidance. The units also benefited from excellent levels of equipment and maintenance with dedicated critical care technologists supporting the service. There was strong clinical and managerial leadership at unit and divisional level. The unit had a vision and business plan for the next five years. There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

The units continued to collect and submit data for the intensive care national audit and research

Summary of findings

centre (ICNARC) and the central cardiac audit database (CCAD) for validation, so they were able to benchmark performance against comparable units. These data showed that apart from delayed discharges, patient outcomes were within the expected ranges when compared with similar critical care units nationally. In terms of unit acquired infections the data indicated much better performance than comparable units. We saw patients, their relatives and friends being treated with care, compassion, dignity and respect.

Maternity and gynaecology

Good



We have rated the maternity and gynaecology services as 'Good' overall. However, some areas required improvement particularly in maternity services.

Gynaecology services (including outpatient services) consistently met national access targets. This included referral to treatment times in all specialties. Urgent 2-week referral timescales were also met, and there were rapid access clinics available. Gynaecology services provided effective care with outcomes comparable with, or better than expected standards.

Across maternity and gynaecology services, medicines were safely stored and the necessary records were maintained. Medical and nursing records were accurate, complete, and securely stored. Patient safety was monitored and incidents were investigated to assist learning and improve care. There was an open culture to support the reporting of incidents. There were good systems in place to identify and support patients who were at risk due to social or emotional circumstances. The senior management team was visible and accessible to staff and managers were seen as supportive and approachable. Patients were very positive about the care and treatment they received at the hospital. Staff were committed, passionate about their work, and proud of the services they offered to patients. Staff were keen to learn and continuously improve the services they offered to patients.

Good practice was observed throughout maternity and gynaecology services but increased demand and a high number of staff vacancies led to ongoing challenges in the maternity service. In the maternity

Summary of findings

unit, there were a high number of incidents reported that were due to staffing issues. Managers were aware of this and recruitment was underway. However although we found staffing levels were adequate at the time of our inspection, the situation was not sustainable and there was limited flexibility in numbers to cope with increased demand, or short notice sickness and absence. Due to the pressures of work, morale was low but staff of all professions supported each other well to work as a team. Medical notes were not always available in maternity clinics and delays in caesarean sections had occurred due to a lack of information. The electronic baby tagging system was not robust. Bed occupancy rates in maternity services were 25% higher than the England average throughout April, May and June 2015. This meant there was insufficient capacity for the numbers of patients attending the maternity unit. This led to patients waiting to be seen in unsuitable areas, waiting for beds, discharging themselves and delays in treatment.

Neonatal services

Good



We have rated neonatal services as 'Good' overall because;

Treatment was based on current best practice guidance and was constantly reviewed to ensure that care met the needs of the baby and identified ways to improve treatment. The service responded to the outcomes of audits and worked collaboratively with other units, research agencies, royal colleges and universities both nationally and internationally to make sure the best possible outcomes were achieved. Patients and parents were supported by a team of specialist nurses who worked in a co-ordinated way to provide care, advice and support throughout the baby's admission. Parents were treated well and involved in the care of their babies. They were positive about their experiences. We observed compassionate care that promoted the wellbeing and future emotional development of babies.

The neonatal team included highly skilled expert practitioners. Staff had opportunities to maintain their competencies and develop additional skills. Nurses were consistently deployed according to best practice guidance, seven days a week and a

Summary of findings

consultant neonatologist was on site 24 hours a day, seven days a week. There were two consultants and a range of specialist support such as specialist nurses available at weekends. Staff complied with infection control measures and the environment and facilities on the unit were clean, well maintained and promoted the safety of babies. Adequate and appropriately maintained emergency equipment was available to quickly meet the needs of deteriorating babies.

The service fostered an open culture and provided training and guidance to staff to ensure they were able to raise all incidents and concerns. Processes were in place to effectively deal with concerns raised. Investigations were robust and action was taken to prevent repeat incidents and ensure lessons learnt were shared with staff and appropriate changes made. The direct leadership team were motivational, focussed and effective in supporting staff and involving stakeholders in relation to providing a good service. There were robust governance systems in place to monitor performance and promote improvements.

Services for children and young people

Good



We rated children and young people's services as 'Good' overall because;

Incidents were reported appropriately using an electronic reporting system. Staff were aware of the system and how to use it. There were examples of learning from incidents and how this learning was shared across the service and trust wide.

Cleanliness and hygiene was of a high standard in the areas we visited and staff followed good practice guidance in relation to the control and prevention of infection. However, improvements were required in relation to the monitoring of medicine fridge temperatures and resuscitation equipment.

Patients received care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were completed and subsequent action plans implemented. Children and young people's services were delivered by caring, committed and compassionate staff that treated people with dignity and respect. Staff actively involved young

Summary of findings

people and their parents and carers in all aspects of their care. Policies and procedures were in place to identify and refer cases of suspected abuse and staff knew the type of concerns they should escalate. However, the processes to highlight previous or ongoing safeguarding or child protection concerns were not robust.

Services were planned and delivered in a way that met the needs of the local population. There were facilities to enable parents to be with their child at all times. We observed that each ward provided a child friendly environment. Interpreting services were available as required. However, improvements were required in relation to referral to treatment times in outpatient services. Long wait times for elective treatment at RMCH remained a challenge with a number of specialities failing to meet the 18 week referral to treatment target.

The hospital had recently undergone an organisational restructure and had moved to having clinical service units. The clinical leads described a very clear vision for their departments. At the time of the inspection, we found this was not yet embedded in practice. There was a robust governance structure in place within the children's division which fed into the trust risk management committee. Monthly governance meetings were held and attended by key professionals. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board. Risk registers were in place and well maintained, although we found that some risks identified by managers were not on the risk register. There was strong clinical and managerial leadership at unit and divisional level. However, the model of care in the PHDU meant that at certain times (out of hours) overall responsibility for the patient's care and treatment was with the parent team and not the intensive care consultant. This represented a risk to timely and consistent decision making. Whilst some progress had been made to meet national guidance following the removal of the Liverpool care pathway in 2014 we found a lack of clarity about what documentation was in place for

Summary of findings

end of life care at RMCH. There was no clear strategy for end of life care throughout children's services. Similarly, there was no clear policy or strategy in place for transition services.

End of life care

Requires improvement



We have rated end of life care services as 'Requires improvement' overall because; Access to specialist palliative care was not available seven days a week other than an advice line provided by the local hospice. Consultant staffing was below the recommended levels for palliative/end of life care. The trust had identified that the service required improvement and had submitted a business case to increase both nursing and medical staff to meet the demands on the SPCT. Whilst some progress had been made to meet national guidance following the removal of the Liverpool care pathway in 2014 there was some confusion and a lack of clarity about what alternative documentation was in place. There was a need to identify and formalise a clear strategy for end of life care throughout adult services. The trust had identified an executive director to lead end of life care for the trust. This was introduced at the time of our inspection. However; there was a dedicated specialist palliative care team (SPCT) who provided support to patients at end of life and to staff caring for patients on the general wards. End of life care provided by staff on wards was found to be safe and personalised to the needs of individual patients. Staff worked hard to meet the individual patient's needs and wishes. They were caring and committed to supporting people at end of life. Individual clinical teams used a combination of evidence based guidance, such as National Institute for Health and Care Excellence (NICE) guidance, Royal Colleges' guidance and quality standards to determine the care provided.

Outpatients and diagnostic imaging

Good



We have rated outpatient and diagnostic services as 'Good' overall because; Incidents were reported and investigated and action taken to limit recurrence. The areas we visited were visibly clean and tidy. Cleanliness, hygiene and infection control was monitored

Summary of findings

monthly and results demonstrated compliance.

Records were of good quality but were not always available; staff used electronic records ensuring minimal impact to patients.

Staff were aware of safeguarding processes and knew what to do when they had concerns relating to abuse and neglect. Patient risks were identified and managed with appropriate measures put in place. Nurse staffing was adequate but there were vacancies in radiology due to national shortages of radiologist staff. Actions were in place to manage the shortfalls. Clinics did not operate seven days a week but on call radiology cover was available at all times. Patients received care based on national and local guidance. Audits were undertaken and discussed monthly in multi-disciplinary teams. The diagnostic imaging department at the MRI used special technology when caring for patients which was available in only two centres in the UK.

We observed staff treating patients with a caring manner and patients described them as kind and courteous. Patients and their carers felt involved in care and that staff explained treatment options in a way they could understand. Key staff acted as leads for care relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. Most patients received appointments within 18 weeks of referral. However, almost a quarter of patients at the MRI waited longer than 60 minutes to be seen once they arrived. The number of patients' not attending appointments had improved from 14% to 10% following actions such as text or phone call reminders. At the MRI, diagnostic reports were not always received in a timely way; however staff were aware of the reasons why and had implemented actions to try to address this.

Risk and governance processes were in place. Action plans were monitored to ensure that risks were mitigated. The culture in services was positive and the majority of staff felt valued. There was a strong ethos in ophthalmology services to drive innovation and research to improve patient outcomes experience and improve service provision.

Manchester Royal Infirmary

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; Neonatal services; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Manchester Royal Infirmary	20
Our inspection team	21
How we carried out this inspection	22
Facts and data about Manchester Royal Infirmary	22
Our ratings for this hospital	22
Findings by main service	24
Action we have told the provider to take	198

Background to Manchester Royal Infirmary

Manchester Royal Infirmary is a large teaching hospital that is part of Central Manchester University Hospitals NHS Foundation Trust. The trust has 1721 beds in total and employs 9,930 staff.

Manchester Royal Infirmary (MRI) provides a full range of general and specialist services including emergency care, critical care, general medicine including elderly care, surgery and outpatient services. The hospital is one of three designated major trauma centres in Greater Manchester. The accident & emergency departments at MRI and the Royal Manchester Children's Hospital see around 145,000 patients each year. The hospital is also a specialist regional centre for kidney and pancreas transplants, haematology and sickle cell disease. The Heart Centre is a major provider of cardiac services in the region, specialising in cardiothoracic surgery and cardiology. Located on the same site as the Manchester Royal Infirmary are the following specialist hospitals:

St Mary's Hospital is a specialist hospital for women, babies and families. More than 1,400 staff, including doctors, nurses, midwives, scientists, clinical and non-clinical support staff work in Saint Mary's hospital. The maternity service offers pregnant women and their families antenatal, delivery and postnatal care. St Mary's hospital also provides a range of specialist gynaecology services for women including: general gynaecology, gynaecology oncology, termination of pregnancy and an emergency gynaecology unit (EGU). The EGU provides 24-hour direct access for patients who have urgent

gynaecological problems or women with problems in early pregnancy. The hospital also provides reproductive medicine services and rapid access services for victims of sexual assault. Saint Mary's Hospital is a tertiary unit which includes a nationally designated tertiary Fetal Medicine Unit. Genomics clinics are also provided in the Manchester centre for genomic medicine, one of the largest and most comprehensive multidisciplinary clinical genetics units in UK. Here, services support pre-natal genetics, dysmorphology, neuromuscular genetics, neuropsychiatric genetics, ophthalmic genetics, cardiac genetics and cancer genetics

The Royal Manchester Children's Hospital (RMCH) provides specialist healthcare services for children and young people throughout the North West, as well as nationally and internationally. With 371 beds it is the largest single-site children's hospital in the UK.

Manchester Royal Eye Hospital (MREH) is a large, specialist ophthalmic teaching hospital. The hospital provides a range of outpatient and elective and unplanned ophthalmology surgical services including: emergency eye surgery, ophthalmic imaging, ultrasound, macular treatment, cataract surgery, electro-diagnosis, laser vision correction surgery, optometry, orthoptics, bionic eye implants and ocular prosthetics.

Detailed findings

Each hospital is based on the trust's main site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a specialist hospital.

We carried out this inspection as part of our comprehensive inspection programme. As part of the inspection we have reported on the core services within each hospital as follows:

- Urgent and Emergency Services at MRI and RMCH
- Medical care services at MRI

- Surgery services at MRI and MREH
- Critical care services at MRI
- Maternity and gynaecology services at St Mary's Hospital
- Neonatal services at St Mary's Hospital
- Children and young people's services at RMCH
- End of life care services at MRI
- Outpatient services at MRI and MREH.

Our inspection team

Our inspection team was led by:

Chair: Nick Hulme, Chief Executive, The Ipswich Hospital NHS Trust

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included CQC inspection managers, CQC inspectors, two CQC pharmacy inspectors, an inspection planner, three data analysts and a variety of specialists for each hospital as follows:

Manchester Royal Infirmary: a CQC inspection manager; six CQC inspectors; a senior A&E nurse; a general nurse with experience in trauma and orthopaedics, A&E, Paediatric A&E and aero med evacuation; Consultant Congenital Cardiothoracic Surgeon; Consultant – Diabetes; Nurse Consultant; FY2 – Medicine (Junior Doctor – GP trainee); Consultant General Surgeon; Head of Theatres & Lead Nurse; Consultant Anaesthetist; Nurse Consultant Critical Care; Retired Consultant in Palliative Care; Consultant Nurse Palliative Care; Senior general nurse – Outpatients department manager; Radiology Manager – Radiographer, Expert by experience - Family carer of person with dementia/older person; Expert by experience - Family carer of adult relative who has a learning disability and high support/complex needs.

Royal Manchester Children's Hospital: A CQC inspection manager; nine CQC inspectors; Paediatric Emergency

Nurse Consultant; Lead Nurse - Paediatrics and Neonatology; Speciality Registrar; Cardiothoracic Theatre Manager; Lead Nurse children's Intensive care and transport/Critical Care Nurse in Paediatrics; Radiology Manager; Consultant Anaesthesia; Nurse Consultant Critical Care; FY4 Junior Doctor; Student nurse; Professional Lead & Designated Nurse Looked After Children; Expert by experience - Family carer of child/young person who uses health services

St Mary's Hospital: A CQC inspection manager; five CQC inspectors; Professor of Gynaecological Research with special expertise in oncology; Neonatal Nurse Practitioner; Paediatric modern matron; Band 7 Midwife / Supervisor of Midwives; Obstetrician and Gynaecologist; Acting Sister Home Birth Team.

Manchester Royal Eye Hospital: A CQC inspection manager; three CQC inspectors; Consultant Ophthalmologist; Retinal Screening Manager, ophthalmology.

In addition the team also included: A Quality Governance/Risk Management consultant; Improving Quality Programme Director; Improving Quality Programme Director; Head of Infection Prevention and Control; Director -WRES Implementation - NHS England; Safeguarding / Supervision Skills Trainer.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Central Manchester University Hospitals NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held listening events in Trafford and Central Manchester on 27 October 2015 when people shared their views and experiences of the trust. Some people also shared their experiences by email or telephone.

The announced inspection of Manchester Royal Infirmary, Royal Manchester Children's Hospital, St Mary's Hospital and the Manchester Royal Eye Hospital took place on 3, 4, 5 and 6 October 2014. We also carried out an unannounced inspection at the Manchester Royal Infirmary, Royal Manchester Children's Hospital and St Mary's Hospital on 26 November 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. 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 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 provided at these services.

Facts and data about Manchester Royal Infirmary

The trust serves a population in Manchester of approximately 514,000. The health of the people in Manchester is generally worse than the England average.

Life expectancy is 8.8 years lower for men and 7.4 years lower for women in the most deprived areas. The rate of hospital stays for alcohol related harm is worse than the England average as is the rate of smoke related deaths and sexually transmitted diseases.

Deprivation in Manchester is higher than the England average and approximately 33.9% of children live in poverty.

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The adult emergency department (ED) at the Manchester Royal Infirmary is one of three designated major trauma centres within Greater Manchester. It is open 24 hours a day, seven days a week to patients over 16 years old. The Walk In Centre (WIC) is located next to the ED and aims to assess and treat patients on the same day without the need to attend the emergency department. Adults and children are accepted. The WIC is open from 8am until 10pm, seven days a week.

The urgent and emergency services at Manchester Royal Infirmary serve a population of 514,000.

The ED has approximately 335 attendances per day. The WIC sees between 100 and 150 patients. There were 101,637 attendances in the adult ED and WIC between April 2014 and March 2015. The WIC saw 1,257 children aged from birth to 16 years. There has been a year on year increase in the numbers of attendances by the over 17s.

Patients access the department by walking into the reception area of ED or WIC, or are brought by ambulance crew into a separate entrance to the Rapid Assessment Unit (RAU). There is also an entrance directly into the resuscitation area for major trauma and critically unwell patients. Access to the WIC can be gained via the ED following triage if treatment at the WIC is more suitable. The ED is divided into three areas according to patient need. The red (resuscitation) area has six bed areas for major trauma and critically unwell patients. The amber area has 16 cubicles and the team aim to see patients

within one hour. The green area has two consulting rooms, four cubicles and four minor injuries cubicles. The department has two mental health assessment rooms in the green area (high and low risk).

There are two triage rooms near the waiting room to assess non-ambulance patients. There are three trolley spaces and two rooms in the RAU area. The Observation Medical Unit (OMU) has 24 beds in gender specific areas. Patients are transferred here from the ED if they require a longer stay but are expected to be discharged within 12 hours (24-48 hours in the case of head injury). The OMU also holds ED clinics and has a large waiting area where patients from ED may be moved to if awaiting results or transport to aid flow in the ED.

Royal Manchester Children's Hospital (RMCH) is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the trust's main site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a children's hospital. RMCH provides urgent care for children across Greater Manchester and is a major trauma centre for children. It regularly achieves 100% for the majority of the criteria in the TARN dashboard. Recent national peer review had found no immediate risks nor serious concerns. Hospital episode statistics data (HES) from April 2014 to March 2015 there were 47,113 children aged between 0 - 16 years old seen in the Royal Manchester Children's Hospital emergency department and 365 young people aged 17+ years old were seen in the Manchester Royal Infirmary emergency department. The children's emergency department (CED) at Royal Manchester Children's Hospital operates 24 hours a day, seven days a week.

Urgent and emergency services

The CED has a six-cubicle assessment area with two consulting rooms for walk in patients. It has two triage rooms; one is used as the ambulance triage area. The resuscitation room has three beds and is attached to the relatives' room which is also used as viewing room for bereaved families. The CED also has an eight-bedded clinical decision unit (CDU), which is used to treat and care for children for a maximum of 12 hours with a view to being discharged home.

We carried out an announced inspection of urgent and emergency services on 4 and 5 November 2015. As part of the inspection we visited the adult and children's emergency departments, the children's clinical decision unit, the walk in centre and the observational medical unit. We also carried out an unannounced visit to the ED, WIC and the OMU on 26 November to review equipment checks and look more closely at safeguarding systems. As part of our inspection, we observed care and treatment and looked at 91 sets of patient records. We spoke with 66 staff, including nurses, doctors, consultants, matrons, an advanced nurse practitioner, support workers, managers and ward co-ordinators, a play specialist, allied health professionals, ambulance crews, security staff and housekeeping staff. We also spoke with 35 patients and their relatives/carers. We looked at information provided by the trust and other relevant information we requested.

Summary of findings

We rated urgent and emergency services as 'Requires improvement' overall because;

In the adult ED, registered nursing and care staff shifts were regularly unfilled in the emergency department. Daily checks of essential equipment were not always completed. The high risk mental health assessment room did not ensure the safety of staff. Systems to safeguard patients were not always reliable and documentation of safeguarding was not consistent.

In the children's ED, improvements in infection control and cleanliness standards were required. Medicines were not always checked regularly or labelled appropriately with the date they were first opened. Records were not always stored securely. The processes to highlight previous or ongoing safeguarding or child protection concerns were not robust. Nurse staffing numbers in the clinical decision unit (CDU) were lower than the required levels on some occasions.

The trust's performance for patients being seen within 4 hours was similar to the England average and the trust exceeded the 95% target between March and May 2015. However, the adult emergency department at MRI consistently failed to meet national targets for time to treatment, time to discharge and ambulance handovers. Around 40% of ambulance handovers had a turnaround time of over 30 minutes between June 2014 and May 2015. In the year from August 2014 to July 2015 there were a total of 860 black breaches across the trust (black breaches are when the time between ambulance arrival and handover of the patient to ED is over 60 minutes). Both the adult's and children's departments were often overcrowded.

However; care and treatment was provided in line with national guidance. The services participated in local and national audits to benchmark their practice and performance and to improve patient care. Patient outcomes were positive and staff were supported to develop their skills and knowledge to achieve these outcomes. Pain relief was provided in a timely manner. There was good multi-disciplinary working and good communication between teams. Patients were treated with dignity and respect. They were involved in their

Urgent and emergency services

care and treatment and supported to make decisions. Patients and their families were offered emotional support and staff acted with care and compassion. Their privacy and confidentiality was respected at all times.

There were clear governance systems in place. There was an open, honest culture with a drive to improve quality. Staff felt supported by leaders and that the senior management team were visible. Departmental risks were recognised and the lessons learnt from incidents and complaints were shared. Research and quality improvement were embedded within the services.

Are urgent and emergency services safe?

Requires improvement



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

Nursing and care staff shifts were regularly unfilled in the adult emergency department (ED). Daily checks of essential equipment were not always completed. The high risk mental health assessment room did not meet the guidelines issued by the Psychiatric Liaison Accreditation Network (PLAN). There was only one door in this room and therefore the safety of staff was not ensured when assessing high risk mental health patients. The low risk mental health room was also used for other clinical activities and contained a sink, hand-sanitising gel and bins. We raised our concerns with the trust at the time of our inspection and saw evidence of planned upgrades to the mental health assessment rooms. This work had not commenced at the time of our announced or unannounced visit and the low risk room was still being used for other clinical activities. Systems to safeguard patients were not always reliable and documentation of safeguarding was not consistent. There was also poor documentation of intentional rounding.

In the children's ED, improvements in infection control and cleanliness standards were required. Medicines were not always checked regularly or labelled appropriately with the date they were first opened. Records were not always stored securely. A new set of record was started when a child attended the emergency department but these were not placed in a temporary folder to ensure they were stored together. The processes to highlight previous or ongoing safeguarding or child protection concerns were not robust. The trust's computer system did not highlight this information to staff when a child attended the children's ED and nurses did not routinely ask questions that would highlight concerns when children were triaged. However, the trust were working to implement the national Child Protection Information System (CP-IS), which would provide real time access to local authority-held child protection information. Nurse staffing numbers in the clinical decision unit (CDU) were lower than the required levels on some occasions.

Incidents

Urgent and emergency services

- Staff were expected to report all incidents and near misses through a trust wide online reporting system.
- Staff were encouraged to report incidents and near misses. They were aware of processes to report incidents and showed us how they would access the online reporting system.
- There was evidence of learning from incidents. Feedback from incidents was shared during handover and discussed in ward meetings. We saw documented evidence of action plans following incident investigations.
- Two serious incidents were reported in the adult emergency department (ED) between August 2014 and July 2015. The department had completed root cause analysis investigations for both incidents using the Serious Incident Framework. These investigations identified action plans to reduce the chance of similar events occurring in the future. Actions had been completed where possible.
- Information provided by the trust showed that between 1 April and 31 July 2015, 276 incidents were reported by the ED, 13 by the walk in centre (WIC) and 65 incidents were reported by the observation medical unit (OMU). The majority of these incidents were graded as no harm showing there was a positive reporting culture within urgent and emergency services.
- In children's urgent and emergency services, there were 70 incidents reported between April to August 2015. Four of them were medical errors that resulted in no harm to the child and 11 related to failures or delays in accessing hospital care.
- Morbidity and mortality was reviewed at the monthly clinical effectiveness meeting. All deaths in the department were reviewed by a consultant.
- Information provided by the trust showed that they monitored incidents and carried out the duty of candour process when applicable. 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 is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- The children and young people's safety thermometer dashboard included data for all of the children's

hospital and was not segregated by service. The data showed there were three level 2 falls between March and May 2015 and 27 pressure ulcers between July 2014 and July 2015.

- Data showed that between October 2014 and September 2015, the ED reported no falls with harm, 13 pressure ulcers and three catheter associated urinary tract infections were found on admission and reported.

Cleanliness, infection control and hygiene

- An 'I am clean' labelling system was in use to identify items that had been cleaned in each of the departments we visited. Antibacterial hand wipes were stored with clean commodes on the OMU for patients to use after toileting. We checked the commodes in the amber area and on the OMU and found them to be clean.
- Staff used the correct personal protective equipment, such as gloves and aprons. There were adequate hand washing facilities and hand-sanitising gel. We saw staff in the ED cleaning their hands before and after patient care in line with trust policy.
- However, best practice for hand hygiene and barrier nursing (for patients with infections) was not always followed in the children's emergency department (CED). In particular, the use of hand gels, washing hands between patients and the use of gloves and aprons whilst delivering care was not always evident during our observations of clinical practice.
- The ED carried out hand hygiene audits to monitor hand washing. The most recent local audit from August 2015 confirmed 91% compliance. This was an improvement on the department's score of 53% in the trust wide audit in May 2015. Following the trust audit the department provided the infection control team with an action plan indicating how they would ensure improvements were made in the identified areas. The next trust wide audit was planned for January 2016.
- The May 2015 hand hygiene audit showed that 71% of staff in the children's Clinical Decision Unit (CDU) and 89% of staff on the CED were compliant with hand hygiene protocols.
- The use and storage of sharps bins was in line with trust policy. Soiled linen was disposed of correctly.
- There were no side rooms on the OMU to prevent the spread of infection. The ward managed this by checking a register to identify if a patient was known to have MRSA or **Carbapenemase-producing Enterobacteriaceae** (CPE). CPE are bacteria that can

Urgent and emergency services

live in the gut of humans and animals. CPE may be harmless and there are no signs or symptoms because a person's immune system keeps them in check. If they get into other parts of the body e.g. the urine or the blood, they can cause an infection and will need treatment. The ward did not admit patients who were known to have MRSA or CPE. If patients were admitted and later found to be MRSA or CPE positive then transfer to an alternative ward with an isolation room was prioritised. We saw this happen during our inspection.

- There were no designated isolation rooms for patients who attended the CED. Instead, a room which held equipment was cleared and used to isolate patients.
- There were no infections reported by ED between September 2014 and August 2015.
- Staff used the aseptic non-touch technique (ANTT). Aseptic technique is a procedure used by medical staff to prevent the spread of infection. Regular audits of the use of ANTT were carried out. The most recent audit showed 100% compliance.
- Each of the areas we visited was visibly clean and tidy.
- The trust's most recent patient experience tracker showed that 89% of patients in ED and 91% in OMU felt that the environment was clean, which was slightly better than meeting the trust target of 85%. However, in the CQC A and E survey, the trust scored worse than other trusts for cleanliness. Patients we spoke with however did not feel the waiting area in the ED was very clean.
- In the May 2015 Patient Led Assessment of the Care Environment (PLACE), the ED scored 91% for cleanliness and the WIC scored 98%.

Environment and equipment

- Patients told us they felt safe in the waiting areas of ED and WIC.
- There were two mental health assessment rooms (a high risk and low risk room). The high risk room was a designated place of safety for patients detained under section 136 of the Mental Health Act. The high risk room did not meet the guidelines issued by the Psychiatric Liaison Accreditation Network (PLAN). There was only one door in this room and therefore the safety of staff was not ensured when assessing high risk mental health patients. The low risk mental health room was also used for other clinical activities and contained a sink, hand-sanitising gel and bins.

- We raised our concerns with the trust at the time of our inspection. We saw evidence of planned upgrades to the mental health assessment rooms and were told that building work was due to start imminently (within two weeks) and would last for approximately six weeks. Plans showed there would be a high risk and low risk room, with the standards meeting the PLAN guidelines. This work had still not commenced at the time of our unannounced visit and the low risk room was still being used for other clinical activities.
- The layout of the environment in the amber and green areas meant that nursing staff were unable to see patients at all times. Staff told us that patients needing closer observation were placed in cubicles near to the nurses' station where possible.
- In the two bedded room in the amber area, it was noted that nurse call bells were not available despite the presence of emergency buzzers. We noted that a patient in this area was unable to call for help when needed. The nurse in charge told us the room was usually used by patients who were unlikely to require the use of a nurse call buzzer but this was not the case during our inspection. There was also one nurse call bell missing from a cubicle in the amber area. The matron on shift agreed this was a safety risk and advised it would be logged as an urgent job.
- When we returned during our unannounced inspection, the matron told us that it had not been possible to install nurse call buzzers. The department were considering the option of wireless buzzers for these cubicles. The matron told us that only mobile patients who were able to care for themselves were using these cubicles and our observations confirmed this.
- The red area contained appropriate and sufficient equipment including paediatric and neonatal emergency equipment. Record logs confirmed that all crash trolleys including defibrillators in ED were checked daily. The major haemorrhage trolley and sepsis trolley in ED were checked and stocked correctly.
- The WIC maintained an AED. If other emergency equipment was required it was brought by the crash team.
- We checked equipment on the OMU and noted that the daily log on the sepsis trolley had not been completed since 30 March 2015. Blood culture bottles were missing and the trolley contained intravenous (IV) fluids that should be locked away to avoid the risk of tampering. We also noted that daily checks on one resuscitation

Urgent and emergency services

trolley had not been completed on 25 days in the three month period from August to October 2015 and on three occasions on another trolley. In the CED, records for October 2015 indicated that the trolley was not checked on five occasions.

- As part of our unannounced inspection, we noted that the sepsis trolley on OMU had not been checked on two days since our announced inspection. One resuscitation trolley had not been checked on four days. The sepsis trolley was not secured and contained IV fluids.
- The entrance to the CED was accessed through automatic doors which led on to a road where ambulances frequently passed. On occasions, staff told us they had stopped children from running into the road because parents could not see the entrance from the waiting area.

Medicines

- In ED, medicines were appropriately stored, prescribed and administered. Controlled drugs were stored and recorded appropriately. Nursing staff carried keys to access medicines cupboards and fridges. In the red area, some drugs were not locked away but were stored safely to ensure quick access in emergencies, for example rapid sequence intubation.
- The monitoring of medicine fridge temperatures in ED did not include recording of maximum and minimum temperatures. This meant that staff would be unaware if the fridge had operated outside of recommended temperature ranges.
- In the CED, we found 30 bottles of medication that had not been labelled with the date they had been opened. Staff could not determine if they had been opened longer than 90 days. Instructions on the medication bottles clearly stated that the content of the bottle should be discarded after 90 days of when it was first opened. We found four examples of expired controlled drugs in the controlled drug cupboard, some of which were for use in emergency situations. We also checked the take home medication cupboard and found medication that was out of date. We raised this with staff at the time of our inspection and the medication was removed.
- Patient Group Directions (PGDs) were in use and there were clear procedures and policies to make sure they were prepared and used in a safe way. PGDs are written instructions which allow specified healthcare

professionals to supply or administer a particular medicine in the absence of a written prescription. PGDs were used by the nursing team effectively to support patient access to medicines in a timely way.

- Prescription forms were stored in an unsecured area at the nurse's station in the green area of the ED which meant that unauthorised persons could access them. We raised this with the ward sister who moved them to a more appropriate place.
- Staff had access to a "to take out" (TTO) cupboard for use when the pharmacy department closed at 6pm. This meant nursing staff could provide medicines for patients to take home without calling the out of hours pharmacist.
- In the WIC, medicines were appropriately stored, prescribed and administered. Blank prescription forms were handled in accordance with national guidance and kept securely.
- When triaging a patient in the CED, nurses asked if the patient had any allergies and this information was documented in records we reviewed. Trust data showed that over 95% of patients triaged at the hospital between 2009 and 2015 were asked about their allergy status.

Records

- Reception staff in ED or nurses in RAU registered patients on an electronic system. This system was used to complete triage, monitor patient flow through the department and to identify when cubicles became free for patient transfer. Staff used paper records alongside this to document care and treatment.
- Nursing staff in the ED amber area, OMU and RAU completed nursing admission booklets. The nursing admission booklet was a comprehensive document including risk assessments and intentional rounding. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
- Staff used early warning score systems (EWS) and carried out routine monitoring to ensure any changes to a patient's medical condition could be promptly identified. The trust wide 'Patient Track' system used in ED and OMU, monitored early warning scores (EWS) and alerted nursing and medical staff if a medical review was required.

Urgent and emergency services

- The ED used “clinical decision support guidelines”. These were condition specific guidelines used by medical staff which complemented additional medical records.
- At the WIC an electronic records system was used to record arrivals and patient notes. The records we reviewed in the WIC were completed correctly.
- New sets of records were started when a child attended the emergency department; however these were not placed in a temporary file to ensure they were stored together. These loose papers were slotted into the front of the records once they had been received on the medical ward and were only filed securely once the clerical staff had the capacity to do so. This meant there was a risk of important medical information getting lost.
- In the CED we checked a random selection of 20 paper based records of children and young people who presented at the department during our inspection. We found that all case notes were incomplete or illegible in some way. For example, the time or dates of when patients were seen by the clinician were missing from seven records. Another example we found was that the medical information written by doctors after an assessment could not be read properly. This led to a risk that information was not readily available to help nursing staff provide the right care or treatment for the patients.
- We reviewed nine records on OMU and in eight cases the safeguarding box had not been completed or had been crossed through. In ED we saw that out of ten patient records, the safeguarding box had been crossed through in two records and not completed at all in four others. It was not clear whether the box had not been completed because there were no safeguarding concerns. This did not comply with trust policy. The failure to complete documentation could mean that safeguarding issues were not appropriately recorded and acted upon.
- There was no robust procedure in place in the WIC to identify safeguarding concerns relating to children. The electronic record system did ‘flag’ patients with a history of safeguarding concerns but there was no system in place to identify children on the local child protection register. This may mean that children attending the WIC were not correctly safeguarded and relevant information may not be shared with other agencies as outlined in “Working Together to Safeguard Children” (2015). The trust had made the decision not to implement a flagging system and had offered a rationale. However, this was not in line with best practice guidance. However, they were working to implement the national Child Protection Information System (CP-IS), which would provide real time access to local authority-held child protection information.
- Similarly, the electronic patient record system did not have any prompts or statutory indicators to alert staff to any previous safeguarding concerns if a child was to re-present at the CED. In addition, triage staff in CED did not routinely ask children or their families/carers any questions that would highlight safeguarding concerns, such as if the patient had a social worker. Therefore a safeguarding concern could go without being identified during the patient’s journey throughout the hospital.
- All staff were expected to complete level two safeguarding training and Band 6 and 7 nurses were expected to complete level three training.
- Training figures showed that 82% of nursing staff in ED, 83% on OMU and 95% at the WIC had undertaken safeguarding training level one against the trust’s target of 90%. Level two safeguarding training completion was 81% in ED, 89% on OMU and 80% at the WIC against a target of 90%. However, trust wide figures showed that 97% of staff had completed safeguarding level three training. Data provided by the trust showed in October 2015, 87% of all staff in children’s services had

Safeguarding

- There were safeguarding policies and procedures in place that covered a range of issues which included domestic violence and sexual abuse, female genital mutilation (FGM) and sexual exploitation. All staff we spoke to in the CED were familiar with FGM and had recently received extensive training on how to identify and report it.
- Staff knew how to refer a safeguarding issue to protect adults and children from abuse. Staff were aware of their responsibilities in relation to safeguarding and understood procedures to make referrals to the local authority.
- However, documentation in the ED admission booklet was safeguarding concerns were not consistently documented in the relevant section of the ED admission booklet. We also noted that the wording and layout of this section did not provide sufficient information to help other staff understand potential safeguarding concerns identified in ED.

Urgent and emergency services

completed level 3 safeguarding training, which was just below the trust's target of 90%. As of March 2015, only 73% of staff in the CED had completed level 2 and 81% of staff had completed level 1.

- The ED had received positive feedback about the number and quality of referrals sent to the multi-agency risk assessment conference (MARAC) following training delivered on domestic abuse.
- Safeguarding information folders were available within each area of the ED with details of how to make referrals. These folders contained agreed pathways for those presenting with self-harm/intent to self-harm, safeguarding children, alcohol and drug issues in under 18s, domestic abuse good practice and safeguarding the children of adult patients.
- Staff contact the safeguarding team for advice Monday to Friday.

Mandatory training

- All staff undertook annual corporate and clinical mandatory training level 1 and 2, which included key topics such as infection control, information governance, health and safety, children and vulnerable adults safeguarding, equality and diversity, fire safety, manual handling and conflict resolution. Training was delivered via on-line courses as well as face to face.
- Records showed that 85% of nursing staff in the ED had up to date corporate and clinical mandatory training. Within the Division of Medicine and Community Services (DMACs) which included ED, the WIC and OMU, 79% of medical staff had up to date clinical mandatory training and 85% were up to date with corporate mandatory training.
- The trust provided the overall mandatory training completion rate for staff across the Children's Hospital (including children's urgent and emergency services); which was 80% for level 1 and 84% for level 2. This meant that the majority of staff had completed their mandatory training. However, this did not meet the trust's target of 90% compliance. Medical staff were not included because training rates of medical staff employed by the trust were coded to divisions according to their main specialty.
- 29% of nurses in ED had completed advanced life support (ALS) training, including two nurses who were also ALS instructors. 25% of staff had also completed advanced paediatric life support training.

- Nursing staff completed the advanced paediatric life support (APLS) course as part of their mandatory training in the CED.

Assessing and responding to patient risk

- A trust wide electronic early warning score (EWS) system was in use in ED and on OMU. The system (known as Patient Track) automatically calculated the EWS and beeped the medical team to alert them that there had been a change in the patient's condition. We observed that clinical observations were not recorded on the EWS for one patient out of five in the red area.
- All children attending CED were assessed by the triage nurse and clinical observations were used to determine how unwell the child was. Children were then prioritised on the basis of how urgently they needed medical attention.
- The trust provided performance data, which showed that between July 2014 and July 2015, the CED achieved the national target set by the Department of Health to clinically assess (triage) patients within 15 minutes of arrival. However, the triage room and assessment areas were away from the waiting room area, making it difficult to see how well patients were after they had been triaged. Therefore, clinical staff relied on reception staff to watch patients. Whilst the reception staff felt they were experienced at identifying patients they thought needed immediate clinical intervention, they were not clinically trained. A bell was used to alert clinical staff when immediate attention was needed. As part of our inspection, we observed receptionists enter the assessment area on two occasions over a ten minute period to ask for assistance from nursing staff to assess an unwell child.
- Triage was undertaken by nursing staff in the RAU and ED green area. Medical staff could be asked to attend urgently if required. Nursing staff completed comprehensive triage assessments and made appropriate decisions based on clinical priority using the Manchester triage system.
- The average time to triage for patients arriving at ED by ambulance was 12 minutes between April 2015 and September 2015. Patients arriving by ambulance should have an initial assessment within 15 minutes of arriving. The national average in 2015 was 6 minutes. Ambulance crews were not able to handover these patients until a cubicle became available.

Urgent and emergency services

- High risk absconders had been recognised as a risk to patient safety. The team in the ED had developed a new process in conjunction with the police and mental health team to manage this risk. We saw this pathway in use with a vulnerable patient following illicit drug use.
- Children and patients over 70 years old were triaged within 15 minutes at the WIC. Staff on reception asked key questions to identify patients with life-threatening illnesses who would need to be treated in the adult or children's ED.
- The ED and OMU used a voice activated paging system to contact other staff. This was a rapid way of contacting other team members and an effective way of requesting support if a patient was deteriorating.
- The ED had a clear pathway for admission to the short stay OMU ward. Admission needed to be agreed by both a consultant (or senior registrar overnight) and lead nurse. The referral form also indicated whether a nurse led discharge was appropriate for the patient.
- Risk assessments were completed on OMU including the risk of falls, use of bed rails, moving and handling assessments, Waterlow (pressure ulcer) assessments and the malnutrition universal screening tool (MUST).
- Safety huddles at shift change over times included a discussion of any high risk patients and any safety concerns within the department. An observation board was in use on the OMU. This identified what risk assessments had been completed for each patient and highlighted risks at a glance.
- Intentional rounding was carried out to monitor patient needs hourly however this was not recorded for one patient in the red area who had been in the department for over ten hours. This meant that there was no record of pain, food, drink or pressure area care. Records we reviewed also showed that intentional rounding was not documented in two cases out of 13.
- If a child attended the adult ED, medical staff were trained to attend to any urgent needs prior to transfer via ambulance if needed to the CED.
- When staff made referrals to the mental health liaison team, a risk assessment was completed to prioritise patients based on need. The referral form also included questions to ensure the safety of the patients and others in the department, with clear guidance on how patients with intent to harm themselves or others should be managed.
- On OMU an acuity tool had been used to work out required nursing staffing but there were frequent shortfalls in nurse cover. Nursing staffing in the ED was calculated based on patient throughput, numbers of cubicles and beds in the resuscitation area.
- The ED had recognised that the current nursing establishment could have a significant impact on patient care and highlighted this on the local risk register. A formal acuity tool had not been used to calculate nursing staffing levels in the ED. This had been identified on the risk register as a required action by the 26 June 2015 but had not been completed at the time of our inspection.
- Staffing levels were planned so there was one nurse caring for five patients in the amber area and one nurse to two patients in the red area. The planned staffing levels in ED also took account of the additional beds in the resuscitation area, but the funding for this was not in the establishment. A proposal had been sent to the board to seek additional permanent funding for this.
- On both days of our announced inspection, the actual registered nurse (RN) staffing in ED was one RN less on the late shift and night shift than planned. On the day of our unannounced visit, there was one RN less than planned on the early shift. Support worker staffing was also one to two members of staff less than planned on the late shifts during our announced and unannounced inspections.
- The average RN fill rate for ED during day shifts was between 77% and 82% for 1 July to 30 September 2015. The night shift fill rate was good at around 96%. However, we also saw that the average fill rate of care staff shifts was low at 56% and 48% at night. This could further reduce patient safety and compromise basic care.
- There was an escalation process in use when staffing levels did not meet the planned levels. Nurse staffing was discussed at a daily meeting of senior staff, including the Chief Operating Officer (COO). Cubicles were closed in ED if nurse staffing levels were not sufficient.
- OMU was staffed by four RNs and four support workers during the day and three RNs and three support workers overnight. In addition to this, one advanced nurse practitioner (ANP) was on the ward between 07.30am to 08.30pm. The ward manager told us there was an

Nursing staffing

Urgent and emergency services

escalation process in place if nursing staffing fell below the planned levels. When nursing staffing was below planned levels, OMU did not take patients into the waiting area from ED.

- OMU shifts were frequently unfilled. The average fill rate during the day was 60.1% and 53.9% at night for RNs. Support worker cover was increased at night to support the shortfall in RNs; however the average fill for support worker shifts during the day was 74.8%.
- The CED had four nursing vacancies at the time of the inspection. The matron told us that these vacancies had been filled and the new nurses were due to start at the beginning of December 2015. To alleviate staffing pressures in the department, the CED coordinator and the advanced nurse practitioner supported the department during busy periods.
- There was a 1:8 nurse to patient staffing ratio in the children's CDU which exceeded the recommended guidance from the Royal College of Nursing (RCN) and the trust's own staffing ratio. This was reported to managers at the time of the inspection and addressed immediately. Senior managers were aware of the shortages and monitored the acuity of patients throughout the day.
- Staffing rotas for the CDU for October 2015 showed that on more than three occasions; the unit was below the recommended RCN guidelines. The matron told us plans were in place to mitigate risks, for example patients were seen by clinicians regularly to speed up discharge home or admission to another ward. The matron regularly reviewed activity in CED and when necessary escalated staffing issues to the service manager.
- An advance nurse practitioner worked three days in CED. The ANP role in the department involved clinically assessing patients; undertaking audits to improve pathways and providing treatment. They were managed by a consultant and the matron and were often called upon to alleviate medical pressures such as when the department was busy.
- Agency nurse usage in ED was 11% during 2014/15.
- Agency staff were inducted to the units with the use of a local induction checklist. We spoke with one agency support worker who had received an induction but this had not been formally documented.
- Agency nurses were not allowed to give intravenous treatment in the ED or on OMU. Nursing and medical staff told us this could delay patient treatment and add

to the workload of other staff in the department. Incident reports showed that this had been an issue. We were told that regular agency nurses were able to undertake trust specific training to allow them to administer and connect IVs but that none of the regular agency nurses had completed this through personal choice.

- Nursing staffing vacancy rate in the ED was 27%, on OMU 26% and at the WIC 25%. The ED had recently recruited four Band 5 nurses and one Band 8a ANP into post.

Medical staffing

- There was consultant presence in the ED from 8am until midnight seven days a week. The ED anticipated that consultant presence would be provided 24 hours a day, 7 days a week by March 2016 as agreed in the NHS major trauma contract. Resident emergency consultant cover was available 24 hours a day, seven days a week. A regular locum senior registrar was also used overnight to provide additional senior cover to support junior doctors and the senior registrar in the establishment.
- Consultant cover was provided on an on-call basis between 10pm and 8am.
- Medical cover on OMU was provided by a consultant or senior registrar from the ED during the day. Medical reviews could be obtained out of hours via a bleep system.
- There was a good level of skill mix within the medical staffing and easy identification of different grades via coloured lanyards. The trust had a higher proportion of registrar staffing and lower numbers of junior doctors than the England average. Consultant numbers were similar to the England average.
- At the time of our inspection there were 16.3 whole time equivalent (WTE) consultants plus one WTE clinical director in post. Consultants also worked across the other urgent care sites within the trust (children's accident and emergency at the Royal Manchester Children's Hospital and the urgent care centre at Trafford General Hospital).
- We reviewed medical staffing rotas in the CED for August 2015 and found there were at least three registrars and three junior doctors on duty between 8am and 6pm. However, cover was limited after 2am when there was one registrar available.
- Consultant cover in the CED was available between 8am to 10pm Monday to Friday and consultants were visible

Urgent and emergency services

in the department for 6.5 hours at the weekend. Thereafter consultants were on-call from home. Senior managers told us there was no consistent specialist registrar grade 4 (ST4) cover in the absence of a consultant.

- The WIC was staffed on a sessional basis by general practitioners (GPs) from Primary Care Manchester, with eight hours per week from a GP employed directly by the trust for governance reasons. There was always one GP at the WIC.
- We observed a handover between medical staff on the CED; the handover was clear and succinct. Junior doctors were given information about individual patients for care and the consultant checked if anyone had any concerns.

Major incident awareness and training

- The ED had two security staff in attendance overnight. The department had recently undertaken a pilot project to look at police presence at the weekends. CCTV was in use in the department.
- Staff were trained in conflict resolution. They told us they called security if they were unable to de-escalate a situation and ultimately the police who usually responded within a few minutes. Staff were aware of 'lock down' procedures.
- The ED received gunshot wound and stabbing victims and although there was no set procedure in place for the security of staff and patients, staff were able to tell us that police were immediately informed in these situations.
- The emergency planning policy included major incidents and the "lock down" policy for use during major incidents, with aggressive patients and in chemical, biological, radiological and nuclear emergencies.
- The department had a major incident cupboard which included appropriate personal protective equipment, suits and tents.
- Senior managers, nurses and medical staff in children's urgent and emergency services were aware of how to deal with any chemical incidents which involved decontaminating patients. The matron and medical staff told us that children who were contaminated and presented at the CED were externally escorted to the Manchester Royal Infirmary emergency department.

- In the CQC A and E survey, the trust scored about the same as other trusts in four out of five of the questions surrounding safety.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



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

Care and treatment was provided in line with national guidance. There were local guidelines in place for the management of commonly seen conditions.

Services participated in local and national audits to benchmark their practice and performance and to improve patient care. Patient outcomes were positive and staff were supported to develop their skills and knowledge to achieve these outcomes. Pain relief was provided in a timely manner. There was good multi-disciplinary working and good communication between teams.

Evidence-based care and treatment

- Care and treatment was based on national best practice guidance produced by organisations such as the College of Emergency Medicine (CEM), the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council (UK).
- The CED used a combination of National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH) Standards to determine the care and treatment provided.
- The ED use 'clinical decision support guidelines'. These were robust, evidence based protocols for commonly seen conditions, for example, fractured neck of femur, stroke, sepsis, paracetamol overdose and head injury. These guidelines were in line with the CEM's 'Clinical Standards for Emergency Departments'.
- Guidelines were easily accessible to junior doctors in the department. Records showed these guidelines had been used and followed appropriately.

Urgent and emergency services

- Services participated in relevant national and local clinical audits to benchmark their performance against best practice, for example the CEM audits for fractured neck of femur and management of sepsis.
- Specific pathways for conditions such as bronchiolitis, asthma and febrile convulsion were displayed on notice boards in the assessment area of CED for parents and staff to view.

Pain relief

- We observed timely administration of pain relief in the triage and in resuscitation areas. Patients told us their pain was well controlled.
- Pain scores were routinely documented in triage. Records showed that patients were asked about pain and that timely pain relief was given.
- There was guidance in place to consider the use of strong analgesia if pain scores were over 8.
- The paediatric pain profile tool was also used to assess pain in children with severe physical and learning impairments.
- The CED had implemented the pain passport; which was a form given to patients so they could comment on their pain relief. Previous feedback from patients and parents highlighted that pain management was not as effective as it could be. To improve pain management, pink stickers were introduced and placed on case notes to remind nurses to check if pain relief had been given.
- The trust scored about the same as other trusts in the CQC A and E survey (2014) on questions relating to pain relief.

Nutrition and hydration

- Meal and drinks rounds were completed regularly and snack boxes were provided in ED. Dietary requirements were catered for on an individual basis.
- We observed the patient liaison worker carrying out these rounds but noted this was not always documented in care records.
- The nursing admission booklet contained the malnutrition universal screening tool (MUST). This assessment had been completed in all the records we reviewed.
- There were water dispensers and vending machines in waiting areas so patients and their relatives and carers could access drinks as needed.
- Food vouchers for the hospital restaurant were given to breastfeeding mothers.

- The trust scored about the same as other trusts in the CQC A and E survey (2014) regarding the availability of food and drink.

Patient outcomes

- The adult and children's services participated in relevant CEM audits to assess their performance against national guidelines.
- In the national audit of severe sepsis and septic shock 2013/2014, the trust performed similar to the England average for eight out of the 12 indicators. It scored better than the England average for three indicators. The trust scored below the England average for the key indicator: Giving the first bolus of intravenous crystalloid fluid within one hour.
- The trust had been working to improve the care of patients with sepsis, and had demonstrated an increase in the number of patients meeting the one hour target for the sepsis six pathway. For example, a trust audit completed in September 2015 showed the average time gap between the prescription of IV antibiotics to administration had been reduced by 34 minutes when compared with the October 2014. Sepsis Six is the name given to a care bundle of medical interventions designed to reduce the mortality and improve the outcomes of patients with sepsis.
- The CEM 2014/15 'Assessing cognitive impairment in older people' audit showed the trust performed better than the national average for the fundamental standard that patients over the age of 75 have a least one early warning score assessment. The department scored 0% in the remaining five standards because cognitive screening was not documented in any of the patient records reviewed. There was an action plan in relation to the results of this audit. Some of the actions identified included: ensuring a full set of observations were completed and documented for all patients over 75 and deciding which screening tool would be most appropriate to use in the ED. A re-audit was planned for February 2016.
- The ED performed better than the national average on the CEM 2013/14 paracetamol overdose audit for full or partial compliance with MHRA guidance and had no serious omissions in treatment.
- The CEM mental health in the ED audit 2014/15 showed that the trust performed better than the national average on both of the fundamental standards. The audit revealed that further improvements were needed

Urgent and emergency services

in relation to three of the remaining eight standards: a mental state examination recorded in patient notes, the documentation of follow up arrangements and time from referral to assessment by the mental health team. The department had identified that performance on the documentation elements may have been poor because the mental health liaison team (MHLT) recorded notes on a separate system. An action plan to improve these standards had been agreed and included improving the use of the mental health clinical decision guideline.

- The major trauma dashboard for quarter one of 2015/16 showed that the ED was performing at or above expected levels for 12 out of 13 measures. Survival rates for major trauma patients were similar to expected.
- The unplanned re-attendance rate was 5.9% which was worse than the England average of 3% and slightly worse than the standard of 5%. The department had recognised that this was higher than the standard and managed this by offering follow up GP appointments in the WIC or ED clinics on OMU.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma and epilepsy was slightly worse than the England average. The highest difference was in asthma readmissions with a rate of 19.8% compared to the England average of 17%.
- Concerns regarding the management of sepsis patients in CED were identified following audit in 2014. The audit indicated there were several areas that required improvement. For example, there were delays in the administration of antibiotics for sepsis patients. In response to this, the service audited their practice and as a result introduced an action plan that included extra training for staff, sepsis stickers on documentation and regular use of a sepsis trolley. Since implementing these actions, the CED had recorded an increase in the number of patients screened and treated for sepsis. In 2014, 41% of patients who were identified with sepsis were assessed and treated within one hour compared to 7% in 2013.
- The gastroenteritis audit in CED had highlighted the need for an integrated pathway; the department were using the audit alongside new NICE guidance to improve their current pathway.
- Children's urgent and emergency services participated in the Trauma Audit and Research Network audit (TARN), which collected data nationally. In 2014/15, the department submitted data for 92% of their trauma

patients. All patient data was submitted within 25 days of discharge or death and the results showed that computerised tomography (CT) scans were organised for all patients who met NICE head injury guidelines, within 60 minutes of arrival.

Competent staff

- Records showed that 80% of nursing staff in ED, 83% of staff in the WIC and 64% of staff on OMU had an up to date appraisal.
- There was an educational development practitioner in post. Regular meetings were held to discuss training and education; clinical skills training was completed in house. A training information board set out the training requirements for each grade of nursing staff.
- Registered nurses were expected to have 12 to 18 months experience in emergency medicine before being trained in triage. Nurses had recently been retrained in triage and an audit confirmed that 95% of triage records reviewed showed that triage had been effective.
- In ED, new nursing staff were supernumerary for three to four weeks to allow them time to complete mandatory and other department specific training. More advanced nurse practitioners were being trained in conjunction with local universities.
- The ED had a twice yearly education and development teaching week, where staff were allocated one day of training to attend identified sessions. The department also held simulation training sessions two to three times per week. We saw these simulation sessions happen on both mornings of our announced visit. Senior nurses told us these sessions were filmed and de-briefing was held to ensure learning took place.
- In ED a skills gap analysis had been undertaken and 50 out of 79 nursing staff completed this. A structured training plan had been developed from this to meet staff needs.
- The ED had a skills escalator programme which included training in all aspects of ED nursing such as wound care, suturing, plastering, sepsis and triage. Competency checklists were seen. There was evidence of nurses using these skills to quickly and effectively manage patients without the need for medical assessment, for example taking blood for lactates to exclude sepsis and carrying out ECGs. ECG (electrocardiogram) is a test that measures the electrical activity of the heart.

Urgent and emergency services

- 75% of medical staff in the division had an up to date appraisal.
- Medical staff told us there was teaching and a journal club every week where best practice was discussed. The department had a process in place where consultants reviewed records on a daily basis with feedback disseminated to individual clinicians or their educational supervisor.
- The mental health liaison team told us that staff in the ED would benefit from more training in mental health to help them better understand this patient group's needs.
- Junior doctors in the CED rotated on a four-monthly basis; they told us this gave them opportunities to upskill themselves in different specialities. During their rotation, doctors had four days of protected training.
- Staff in CED were appropriately trained to triage patients. Staff were required to have two years of nursing experience in the department before they were able to triage patients.
- In children's urgent and emergency services, there were clear induction processes for staff which included competency assessments for procedures such as administration of medicines, infection control and discharge of patients.

Multidisciplinary working

- Staff told us that the multi-disciplinary team (MDT) worked effectively. We saw good multi-disciplinary working during our inspection and noted that communication between staff was respectful and supportive.
- MDT meetings were held on a monthly basis in the CED to make it more accessible for clinical and nursing staff to attend. Designated team members from teams such as pharmacy, children and adolescents mental health and safeguarding attended the meetings to discuss any concerns and ways in which they could improve working together.
- We observed effective handovers of patients between paramedic and RAU staff.
- During the daily ED safety huddle, key members of staff explained their roles, capabilities and priorities to ensure all team members had a good understanding of the team on that shift.
- The department had good links with mental health services. The specialist mental health team was available 24 hours a day, seven days a week, with a senior doctor available from 9am to 9pm. During our

announced inspection, we observed a patient with mental health needs being triaged and referred to the mental health team; the team attended the department quickly to complete an assessment.

- Occupational therapy and physiotherapy was provided on OMU from Monday to Friday. The therapy team aimed to respond to referrals within 24 hours but prioritised referrals based on clinical need.
- The ED had input from two extended scope practitioner (ESP) physiotherapists in the green area on two days per week. The ESP physiotherapists assessed and treated patients with musculoskeletal problems.
- There was access to specialist nurses within ED and OMU, including an alcohol specialist nurse and a fractured neck of femur specialist nurse.
- Children in the WIC were referred to the community paediatric nurses for follow up when required.

Seven-day services

- The ED was working towards the provision of consultant cover 24 hours a day as agreed in the NHS major trauma contract. It was anticipated that consultant cover would be provided 24 hours a day, 7 days a week by March 2016.
- The trust had completed a seven day service baseline assessment and was undertaking further work to identify gaps and necessary service developments. There was a seven day working page on the intranet site to provide staff with information.
- The CED and the clinical decision unit (CDU) were open 24 hours a day, seven days per week.
- Child and adolescent mental health services were available to provide support seven days a week to ensure that children and young people did not have to wait to have their mental health needs assessed.

Access to information

- The ED and WIC used a computer based system to register patients arriving. Triage also took place on this system in ED. Paper notes were used alongside the trust's electronic early warning score system. Patient notes in the WIC were recorded electronically.
- Staff could also access test results on the trust's electronic reporting system.
- Paper notes completed in ED were copied and transferred with the patient to OMU. These notes were then continued and used by the MDT.

Urgent and emergency services

- Staff in the CED used the new electronic system, which was also used across the children's hospital, to record patient information. The system held all patient details such as personal details, previous attendance information, test results and observations. This allowed staff to review and manage records in different areas of the hospital.
- Staff had access to national guidance reference material via the trust intranet that supported clinical decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Doctors and nurses obtained verbal consent from patients before providing care and treatment where possible. We heard staff explaining treatments and diagnoses to patients, checking their understanding and asking permission to undertake examination and perform tests.
- Staff in ED were able to give examples of when a patient's capacity to make decisions may be limited and were able to tell us about consent, implied consent, best interests decisions and deprivation of liberty safeguards (DoLS).
- Patients in ED and OMU told us they were asked for their consent before treatment.
- Nursing staff on OMU reported that medical staff completed mental capacity assessments. If nurses were concerned about mental capacity they requested reviews, particularly following screening for cognitive impairment.
- Consent was obtained from parents for each child and young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- It was clear during discussions with staff in the CED that they used the principles of the Fraser guidelines (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) when making decisions about the ability of a young person to consent to procedures.
- Trust wide figures showed that 83% of staff had completed level one Mental Capacity Act/DoLS training and 76% had completed level two against the trust target of 80%.

Are urgent and emergency services caring?

Good



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

Patients were treated with dignity and respect. They were involved in their care and treatment and supported to make decisions.

Patients and their families were offered emotional support and staff acted with care and compassion. Their privacy and confidentiality was respected at all times.

Compassionate care

- The NHS Friends and Family Test (FFT) results for September 2015 show that 85% of patients were 'extremely likely' or 'likely' to recommend urgent and emergency services at the Manchester Royal Infirmary (MRI) compared with the national average of 88%. The FFT result had also been slightly worse than the national average between July 2014 and August 2015. The response rate to the FFT was slightly better than the national average at around 16%. Nursing staff told us they use hand held devices at the patient's bedside to gain feedback.
- The CED also participated in the NHS friends and family test. However the response rate was only 2.4%, this was worse than the national average of 14.8%.
- Staff provided care in a compassionate way and developed a good rapport with patients. Staff ensured patient privacy and dignity was maintained, including in high pressured emergency situations in the red area.
- Staff provided reassurance and comfort to parents who were anxious or worried.
- We observed staff interactions with patients living with dementia and mental health problems and noted that their approach was compassionate.
- Staff in the ED managed patients who displayed disruptive behaviours very well, de-escalating situations and maintaining a respectful approach.
- The WIC allowed patients to write down their personal details and health concerns to maintain privacy and dignity in a busy waiting area.

Urgent and emergency services

- The ED staff had created a store of clothes and provided these to homeless patients attending the department in need of clean and dry clothing.
- Patients told us staff were attentive and caring. They said that reception staff were helpful. They felt their privacy and dignity was maintained during their care.
- The trust scored about the same as other trusts in all questions relating to caring and privacy and dignity on the CQC A and E survey.
- The trust's patient experience dashboard for September 2015 showed 89% of patients in ED and 88% on OMU felt they were given privacy and dignity.

Understanding and involvement of patients and those close to them

- We heard staff giving patients information about their care and explaining the next steps involved in their treatment.
- Staff in the CED engaged with young people and their families. We saw that they introduced themselves when they initially came into see the patient and kept them informed about their treatment and care.
- Staff in the CED involved parents, children and young people in the planning for discharge or transfer to another ward. Staff used leaflets to explain the next steps of care when a patient was being discharged home and when a patient was being admitted to a ward; we saw staff explain what parents should expect over the next few days.
- Patients in the WIC told us they didn't know when they would be seen or if they would be seen in order of arrival. In the ED amber area, two patients told us they did not feel they knew enough about their treatment and another felt that she had not been asked how she was feeling. One patient told us he had been kept well informed.
- Patients on OMU told us they felt involved and informed about their care and treatment.
- In the ED, a patient liaison worker was available between 10am and 6pm. This member of staff offered food and drink and had additional time to spend supporting patients and their families.
- The trust's patient experience dashboard for September 2015 showed 93% of patients in ED and 88% on OMU felt that they and their families were involved in their care.

Emotional support

- The play specialist was visible on the CED. Observations of patients in the waiting room before and after triage helped prioritise which children needed input from the play specialist.
- We saw that where possible and suitable, families were supported to be with their relatives in the ED's resuscitation area. When this was not appropriate, staff gave them access to one of the two private relatives' rooms.
- The advanced nurse practitioners (ANPs) and trainee ANPs told us they had good relationships with frequent attenders to the departments and offered them additional emotional support where required.
- Patients and their relatives had access to the hospital chaplaincy if needed.

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

Requires improvement



We rated urgent and emergency services as 'Requires improvement' for Responsive because;

The trust's performance for patients being seen within 4 hours was similar to the England average and the trust exceeded the 95% target between March and May 2015. However, the adult emergency department at MRI consistently failed to meet national targets for time to treatment, time to discharge and ambulance handovers. Around 40% of ambulance handovers had a turnaround time of over 30 minutes between June 2014 and May 2015. In the year from August 2014 to July 2015 there were a total of 860 black breaches across the trust (black breaches are when the time between ambulance arrival and handover of the patient to ED is over 60 minutes).

Both the adult's and children's departments were often overcrowded. At the time of our visit, the CED reached full capacity and we saw the matron and the clinical lead contact operational managers across the hospital to increase the flow of patients. Records showed that between April and September 2015, 15% of patients waiting in the ED to be admitted to the MRI were waiting between four and 12 hours. This was worse than the England average of around 2%

Urgent and emergency services

However, the numbers of patients leaving before being seen was better than the national average and the Department of Health target. Staff knew how to respond to patients with additional needs such as patients living with dementia or a learning disability.

Service planning and delivery to meet the needs of local people

- The trust had taken over the running of the WIC in February 2015. Patients told us they visited the WIC when they were unable to get an appointment at their own GP practice or when other walk in centres were closed. The location of this centre also enabled patients attending ED to be redirected to this service when appropriate.
- The ED was one of three designated major trauma sites within the Greater Manchester area.
- There were six beds in the red (resuscitation) area. This area had recently been opened with an increase in the number of beds from four to six. In ED, there was a separate entrance to the rapid assessment unit (RAU) where patients arriving by ambulance were brought. There was a direct entrance into the red area.
- There were two consulting rooms on the OMU that were used for ED clinics. These clinics offered early follow up appointments to ED patients. There were four bays on the OMU providing single sex accommodation for a total of 26 patients.
- There was sufficient seating in the waiting areas during our inspection, but there was limited space in the WIC for pushchairs and prams. There were two triage rooms with direct access from the waiting area.
- The design and layout of the children's emergency department (CED) was such that conversations could be overheard between staff and parents. The waiting room and the main assessment area were small. When the CED became particularly busy, seating was limited in the waiting area and it was difficult for people to manoeuvre prams and for children to play. The clinical consultant lead and matron confirmed plans had been submitted to extend the resuscitation area because space was limited. However, no proposal date for the refurbishment had been confirmed.
- The entrance to the CED opened out on to a busy road frequently accessed by ambulances. We were told that on some occasions, reception and clinical staff had to stop children from leaving and stepping out into the road.

- The CED did not have a dedicated play area for children; toys in the department were limited. We saw a cupboard of games and toys in the relatives' room but these were not used or shared across the department.
- A room was available in the CED for patients who had a disability or behaviour that challenges, so that they could be away from busy areas to reduce their anxiety levels. However, the room was dull and there were no toys or interactive games suitable to stimulate patients.
- The CED had plans in place for winter, which involved recruitment of extra nursing and medical staff. To alleviate winter pressures, patients were reviewed regularly so they could be transferred to wards or discharged home sooner.
- The CED cared for a diverse ethnic population of patients and at times these patients did not know how to book appointments with their General Practitioner (GP) or they were new to the Manchester area. The receptionist in the CED was supported by a General Practitioner (GP) administrator, whose role was to book appointments with the GP for patients seen in the CED. By booking these appointments and signposting patients to facilities such as the walk in centre, the department aimed to educate patients about services in the community.
- Staff told us that on some occasions, a fourth bed had been placed in the resuscitation room in CED to accommodate an emergency and although it was safe, it was difficult to manage as the space was limited. During our inspection we saw three patients in the resuscitation area at one time; the space became cramped with limited room to move.

Meeting people's individual needs

- The department had an electronic 'tell us what you think' system in use, including translation into seven languages. Patient information leaflets were available in English, however on the back of the leaflets, there were instructions, in several different languages for patients, identifying how they could obtain a copy in their preferred language.
- An in-house interpretation and translation service was available to provide face to face and telephone translation. Staff on shift who spoke more than one language were also utilised to support patients who did not speak English.
- The trust had undertaken work with the deaf and blind communities but hearing impaired patients said there

Urgent and emergency services

were no systems in place to support them in the busy waiting area of ED. They told us they needed to sit near to the triage room so as not to miss their name being called.

- Staff told us they had undertaken e-learning sessions on dementia and learning disabilities. There was an electronic flagging system to identify patients with a learning disability, but no system was in place to identify people living with dementia in the ED or the WIC. For patients on the OMU, this was identified on the electronic patient recording system. This system contained risk assessments and alerted nursing staff to relevant risks. Nursing staff made referrals to the dementia or learning disabilities nurse specialists when required.
- Staff described how they responded to patients with additional needs such as patients living with dementia or a learning disability. They gave examples of altering communication style to the needs of the patient and assessing risk, particularly in regard to the care environment.
- The ED had named link nurse teams for safeguarding, alcohol misuse, homelessness and regular attenders to the department. Frequent attender management plans were available in the records we reviewed. These plans included individualised actions to be taken for patients who regularly attended the ED but who did not require emergency medical care.
- The mental health liaison team (MHLT) had devised a proforma for use in the ED enabling direct referral to the MHLT from triage. The MHLT aimed to respond within one hour to high risk patients and within two hours to moderate risk patients.
- The WIC did not provide a child friendly area or have any toys or books available for children.
- Staff in the CED told us they called upon the child and adolescent mental health service (CAMHS) team if they needed guidance or advice when caring for children with complex mental health needs or for children with a learning disability.
- Staff told us how they adapted to requests for cultural reasons following deaths in the CED.

Access and flow

- The trust's performance for patients being seen, treated, admitted or discharged within 4 hours was similar to the England average and the trust exceeded the Department of Health 95% target between March and

May 2015. The children's hospital met this target between July 2014 and August 2015. Similarly the children's hospital met the Department of Health target for 95% of patients to be clinically assessed (triaged) within 15 minutes of arrival between July 2014 and August 2015.

- However, there were capacity and waiting time challenges within the ED at the Manchester Royal Infirmary (MRI). The ED had failed to meet the Department of Health (DH) target to assess, treat and discharge or admit 95% of patients within four hours for any month between April and September 2015. The average proportion of patients treated within four hours for this period was 90.6%. The ED had not met the 95% target for any month between August 2014 and July 2015.
- There had been increases in attendances and admissions over and above the national average and pressure had continued during April to October 2015, with a further 5% increase in attendances on 2014/15 and a 20% increase in acuity through the MRI. The trust had identified the increase in demand and the potential impact it could have on patient outcomes and experience. As a result this was included on the trust risk register and several control measures had been implemented to minimise and manage the risk. For example, the development of a transformation project, an increase in bed capacity across the trust to manage patient flow and regular escalation and bed management meetings.
- Breaches of the four hour target were identified to the lead nurse and a senior nurse from ED attended the bed management meeting four times per day. This meant that capacity issues were discussed outside of the department and actions to improve flow could be taken within the hospital where possible.
- The ED had consistently failed to meet the DH target that ambulance handovers must take place within 15 minutes and that no ambulance should wait over 30 minutes. Between April and September 2015, 1226 ambulances waited over 30 minutes to handover the patient, with a total of 305 ambulances waiting for over 60 minutes. Around 40% of ambulance handovers had a turnaround time of over 30 minutes between June 2014 and May 2015. In the year from August 2014 to July 2015

Urgent and emergency services

there were a total of 860 black breaches across the trust (black breaches are when the time between ambulance arrival and handover of the patient to ED is over 60 minutes).

- Staff told us that patients waited on trollies in the corridor of the amber area if no cubicles were available and recognised that this was not ideal. They said there had been 13 patients on the corridor waiting for a cubicle on the Monday before our inspection. Incident reports confirmed that patients waited on corridors but it was not clear if this was always reported. During our unannounced inspection there were up to three patients were waiting on the corridor for triage or cubicles.
- The median time to treatment was 69 mins between April and September 2015 which was worse than the standard of 60 minutes and national average of around 55 minutes.
- Records showed that between April and September 2015, 15% of patients waiting to be admitted to the hospital were waiting between four and 12 hours. This was worse than the England average of around 2%. There were no waits of over 12 hours which meets the Department of Health's target.
- On the second day of our announced inspection, two patients had been in the department for over 10 hours. We noted that one of these patients did not have intentional rounding documented, although we observed that his needs were being attended to and had been offered food and drink. Staff told us that where possible, patients were transferred from trollies onto beds. Records showed that patients waiting for long periods in the department were assisted to change position and their hygiene needs were met. Intentional rounding and the provision of food or drinks however, was not always documented.
- In children's urgent and emergency services, all breaches of the four hour target were reviewed at a weekly performance meeting. Senior managers acknowledged that one of their biggest challenges in the department was access and flow. This was echoed by staff within the CED. However, all staff we spoke to felt it was important to transfer patients to the right ward so they didn't need to be moved more than once and to reduce anxieties in children.
- At the time of the inspection we observed more than five ambulance handovers in the CED, all of which were succinct and took between 3-6 minutes for the initial assessment to take place. This was in line with the national average.
- Ward 75 was a general paediatric ward next to the CED department. It was a 28 bedded ward and was also managed by the CED matron. If at times there were no beds to place patients in specialist wards, patients who required further treatment or investigations were transferred to this ward. The matron told us this was helpful when managing the flow of patients through the CED.
- In busy periods, staff escalated their concerns about the levels of activity in the CED, such as the number of attendees per hour, to the matron. We saw this happen at the time of the inspection and both the clinical manager and the matron were visible and monitored the department closely. They actively called other ward managers in the children's hospital to speed the flow of patients from CED to specific wards. Medical staff reviewed all patients in the clinical decision unit (CDU) and discharged those who were medically safe to go home.
- The numbers of patients leaving the ED before being seen was 1.4%. This was better than the national average and the DH target of 5%.
- On the A and E survey, the trust scored about the same as others when asked about the overall time spent in the ED.

Learning from complaints and concerns

- Information about how to make a complaint was displayed in the department. Information leaflets were available giving details of the Patient Advice and Liaison Service.
- The trust's quality committee monitored formal and informal complaints on a quarterly and annual basis. The division held a weekly complaints meeting where open complaints were discussed. The trust aimed to acknowledge formal complaints within 3 days and told us this was achieved for 100% of complaints in the first quarter of 2015/2016.
- There were 53 complaints about care in the ED, four complaints about the OMU and one about the WIC between August 2014 and August 2015. Complaints themes were staff attitude, delayed diagnosis, general nursing or medical care and communication failure.

Urgent and emergency services

- The CED received 23 complaints between August 2014 and August 2015. The two main complaint reasons were delays in waiting for treatment and communication. As a result senior leaders had asked staff to keep patients and their families informed and to apologise when treatment or care was delayed. Whilst on inspection, we saw a consultant apologise to a parent about the time it took for their child to be seen and the reason for the delay was explained.
- Lessons learned and safer standards were shared regularly with the team. The trust produced monthly 'lessons learned' bulletins.

Are urgent and emergency services well-led?

Good



We have rated urgent and emergency services as 'Good' for Well-led because;

There was good governance and leadership in place. There was an open, honest culture with a drive to improve quality. The trust values were well understood in the department. Staff felt supported by leaders and that the senior management team were visible. Departmental risks were recognised and lessons learnt from incidents and complaints was shared. Research and quality improvement were embedded within the department.

Vision and strategy for this service

- Staff told us they were aware of the trust's values: 'Pride, respect, empathy, consideration, compassion and dignity'. There was no specific vision statement for the ED.
- The trust recognised that the environment of care and the ED infrastructure in MRI required significant investment to support the improvement of patient flow and to improve the patient experience.
- As part of the 'Healthier Together' programme, there was a five year project to develop and expand the ED at MRI phased between 2014/15 and 2019/20. This programme was dependent upon £78.5m (excluding VAT) of funding from the Public Dividend Capital.

- Staff were aware of the departmental vision and values in children's urgent and emergency services and effectively discussed how they adapted care to ensure they delivered this to patients.

Governance, risk management and quality measurement

- The departments we visited used the trust quality dashboards to show staff and patients how they were performing. This was displayed on noticeboards and included key information about patient experience and quality of care.
- Clinical effectiveness meetings were held monthly, chaired by the divisional director and attended by consultants, nurse managers and senior nurses. We reviewed the minutes of these meetings and saw that governance processes within urgent and emergency services were robust.
- Staff told us about the main risks within the department. The risk register had been updated and reflected the risks that staff identified. The majority of risks on the register in ED included control measures and the actions that had been taken to minimise the impact of identified risks (six identified risks did not detail the control measures in place). However, the actions detailed had not so far reduced the on-going risk rating for each risk.
- There were 28 risks identified on the risk register for ED and the WIC. Nineteen of these risks had been identified more than two years ago, with the oldest of these risks dating back to 2006. The majority of those risks that had been on the register for a long time were long standing issues that were not easily resolved such as 24 hour consultant cover (identified in 2006) and the size and layout of ED (identified in 2009).

Leadership of service

- There was a clear leadership structure in place within the adult emergency directorate. The clinical director was supported by a directorate manager and a lead nurse.
- Senior staff had a strong sense of 'Team MRI'. They told us they had a daily meeting with the hospital's senior team, with the Chief Operating Officer in attendance. Senior staff felt that managers were visible and supportive.

Urgent and emergency services

- The leadership team recognised the challenges the ED faced including the physical environment, recruitment of staff and flow within the department.
- Nursing staff in the CED felt their managers and matrons were visible and approachable. Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.
- However, nursing staff in the children's hospital told us they did not feel the trust board were visible or understood their service. However they did receive trust emails to keep them updated on board developments.
- Ward meetings were held monthly for each area we visited and minutes were emailed to all staff. A copy was also stored in the staff room. Information was shared at handovers on a day to day basis.
- The ED had recently undertaken a team performance project. This project helped the team to identify changes needed in working practices, including the introduction of a team leader within the administration and clerical team. Staff told us the improvement project would be reviewed but there was no agreed timescale for this review.
- Children and young people's services were involved in the trust's wider reward and recognition strategy. Staff were recognised for their contributions to patient care from the perspective of the trust's core values of pride, respect, empathy, dignity, compassion and consideration.

Culture within the service

- Staff described the culture within the services as open and honest and felt supported by immediate management. They spoke positively about the teams they worked in and felt proud of the care they delivered. We saw staff treating each other with respect.
- The hospital said it was committed to treating people equally and there was a trust wide equality strategy.
- Sickness rates during 2014/15 for ED was 5.4% and 7.6% for OMU nursing staff. The average for the division was around 7.5%. Eighteen staff had left ED during that period and six had left OMU meaning that turnover rates were high at 24-34% for 2014/15. Sickness rates for medical staff was low at less than 1%.

Public engagement

- Patients views were routinely gained using an electronic patient experience tracker that was taken to the patient's bedside. These views formed part of the quality dashboards. The dashboards showed that overall quality on OMU was around the trust's expected scores between September 2014 and September 2015. Overall quality scores for ED based on patient feedback showed improvements had been made since April 2015 and scores for August and September 2015 were at expected levels.
- The CED was actively pursuing patient feedback. We observed three different methods of ascertaining the views of patients and their relatives. Feedback from patients identified flaws in the way pain relief was managed and as a result, the department introduced a pain passport, this was a feedback form given to patients and their families to comment on how effective and responsive staff were in administering pain relief.

Staff engagement







Innovation, improvement and sustainability

- There was a dedicated transformation programme on urgent & emergency care, led by the director of transformation. This was monitored through the transformation programme strategy board and in turn reported quarterly to the board of directors by the chief operating officer.
- The CED project improvement plan had identified areas for improvement such as the lack of space in the CED department and increased service demand. The service had four ongoing goals to deliver against Royal Manchester Children's Hospital strategic goals but no timelines had been set to deliver the plans. The service was reviewing the site space and their current resources. Training staff is ongoing so that they are fully informed in their role and the service is working with international links to expand their research programme.
- There was evidence of service and quality improvement plans within urgent and emergency care, for example the ED had undertaken a quality improvement project in sepsis recognition and treatment.
- A range of extended and enhanced roles have been introduced across the urgent care pathway such as Emergency Nurse Practitioners, Advanced Practitioners, and technicians to support the patient pathway.

Urgent and emergency services

- The leadership team in ED had recognised the need for additional capacity in the red (resuscitation) area. Following £2million investment, the new red area had recently been opened (October 2015) with an additional two beds, bringing the total number of beds to six.
- The ED was leading on five multi-centre research trials, seven single site studies and participating in many more. The EMERGING research team was named 'Research Team of the Year 2014' at the Greater Manchester Annual Research Awards.
- The department were working on 'Project Red', a redevelopment project to extend the ED and this included plans for a helipad. However, no final agreements had been made and there was no timeline for this project.
- The OMU had recently received 'silver' on the Trust's ward accreditation programme. The ED had not received accreditation from this programme of work as the accreditation did not yet fit with the complexities of an emergency department.

Medical care (including older people's care)

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

Information about the service

Medical care services at Manchester Royal Infirmary provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology. The heart centre is a major provider of cardiac services in the region, specialising in cardiothoracic surgery and cardiology. Specialist medicine services also provide an acute kidney injury service and renal satellite services. There are 496 medical beds and around 2072 members of staff employed in medical services.

The hospital provides medical care services to a population of 514,000 and between January 2014 and December 2014 had around 41,000 admissions.

We visited Manchester Royal Infirmary as part of our announced inspection on 4 and 5 November 2015. As part of our inspection we visited wards 30(general medicine), 31(rehabilitation), 44(haematology), 45(acute medical male), 46(acute medical female), 27(heart centre), 7(heart centre), 36(renal), AM1(respiratory), AM2(respiratory), AM3(gastroenterology), AM4(gastroenterology), acute cardiac centre, acute medical unit(AMU), ambulatory care, discharge lounge and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 34 care records and 38 medication records. We spoke with five family members, 19 patients and 71 staff of different grades, including nurses, doctors, ward managers, matrons, a housekeeper, a security guard 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.

Medical care (including older people's care)

Summary of findings

We rated medical care services as 'Good' overall because;

Care was provided in line with national best practice guidelines and medical care services participated in the majority of clinical audits where they were eligible to take part. National audits indicated that the majority of patients experienced good outcomes. Improvements had been made in the provision of stroke care although some improvements were still required. Action plans were in progress where areas for improvement had been identified. There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

Incidents were reported and investigated appropriately. Lessons were learnt and improvements made following incidents and findings were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices. Staff understood the key principles around obtaining informed consent, the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). However DoLS paperwork could be variable, particularly in relation to emergency applications.

Medical services met the 18 week standards for referral to treatment times in all specialities from September 2013 to July 2015. Patients were sometimes placed on wards that were not best suited to meet their needs (also known as outliers). However, there were good systems in place for the management of these patients to ensure they received a regular medical review. Services took into account the needs of the local people. The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not scheme for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. There was access to translation services and leaflets were available for patients about the services and the care they were receiving.

There were governance systems in place which included a risk register. Some risks on the register had no actions

or control measures identified so it was not clear if they were being managed effectively. It was unclear from the evidence provided if services were implementing the agreed governance framework or discussing risks at the relevant meetings. All staff knew the trust vision and values framework. Staff felt supported and morale was good. All staff were committed to delivering good quality care and were motivated to work at the hospital.

However, nursing staffing levels on some of the wards did not meet the planned requirements, especially at night, on the endoscopy unit and the acute medical unit. Records were left unsecured on the wards we visited and there was a risk that personal information was available to members of the public. There were standards for record keeping that required improvement but records did include a treatment plan for each patient. There were a number of patients who were moved during the night on some wards and half of all patients experienced one or more moves during their stay. Patients' privacy and dignity was not always maintained on the endoscopy unit as there were male and female patients in hospital gowns in the same waiting room with only a temporary screen to separate them. Plans were in place to address this.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated medical care services as 'Requires improvement' for Safe because;

There were a number of items of electrical equipment on ward AM1 that did not have an up to date electrical safety certificate and there was a broken lock on the door of the room used to store clinical waste. Oxygen cylinders were not always stored in line with health and safety best practice guidelines. Incidents were reported and investigated appropriately. Lessons were learnt and improvements made following investigations, however it was unclear if this learning was shared across the wider services in specialist medicine.

There were systems for the handling and disposal of medicines. However on some of the wards, staff did not know how to reset the thermometer to check the fridge temperature ranges and there was no indication of any action taken when the temperatures of medication fridges were outside the recommended range. There was a lack of information and guidance for nurses when administering some 'when required' medicines with variable doses.

Records trolleys were left unlocked on some of the wards we visited but records we reviewed were documented accurately and medical decisions were documented clearly. Staff attended mandatory training courses but compliance rates were below the trust target. There were some staff vacancies which were noted on the risk register and actions had been identified to mitigate this risk. Nurse staffing levels did not meet planned requirements on some wards, for example on the acute medical unit (AMU) and the endoscopy unit. There was no dedicated consultant for the AMU.

Incidents

- There were systems for reporting actual and near miss incidents across medical care services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. Staff understood their responsibilities to raise concerns and record safety incidents.

- There had been one never event reported in medical care services. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. The incident related to an incorrect patient taken to the renal dialysis unit where a femoral line was inserted. The incident had been fully investigated and changes made to practice. For example, an additional prompt had been added to the endoscopy checklist to visually check all equipment before and after procedures to ensure no retained items.
- From August 2014 to July 2015 medical care services at the hospital reported 6255 incidents. 16 were serious incidents. These were mainly in relation to pressure ulcers, sub-optimal care of the deteriorating patient, and a medication incident whilst in hospital. All serious incidents had been investigated and action had been taken to prevent re-occurrence. The other reported incidents were rated as low or moderate harm. This indicated that the service had a positive culture of reporting incidents.
- Learning from incidents was discussed during team meetings, shared via email and lessons learned information was displayed on notice boards in staff and public areas.
- Minutes of the main divisional management meeting in acute medicine showed that incidents were not discussed. However they were discussed at the ward managers meeting and learning was identified to improve the care provided.
- Minutes of the clinical effectiveness board meetings in specialist medicine showed that incidents were discussed but there was limited evidence that any shared learning or required actions were identified to ensure learning improved the care provided across specialist services.
- The trust policy for duty of candour had been implemented. 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. Staff understood the principles of duty of candour and could clearly outline when this would be applied. We saw evidence of the policy being applied appropriately.

Medical care (including older people's care)

- Multidisciplinary mortality and morbidity reviews were held and medical services had identified key themes, for example, poor documentation and delays in discharges. The themes were discussed at the ward managers meetings to identify learning for each ward.

Safety thermometer

- The trust submitted data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- From October 2014 to September 2015 there were 13 pressure ulcers reported across all medical care services. There were no falls that resulted in harm and three catheter acquired urinary tract infections had occurred during this period.
- Results of the safety thermometer were displayed on every ward and area we visited. The results related to that individual ward or area. Ward managers had actions in place for improvement when there had been a reduction in performance against previous months.

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well maintained. All staff were aware of current infection prevention and control guidelines. This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Between June 2014 and April 2015 there had been six incidents of MRSA, 104 incidents of MSSA (of which 47 were attributable to the trust) and 63 incidents of Clostridium Difficile across the trust (of which 37 were non-attributable to the trust).
- Between April 2014 and March 2015 there had been eight occasions when medical wards at the hospital had been closed due to an outbreak of diarrhoea and vomiting. During the same period there had been seven occasions when medical wards at the hospital had been closed due to carbapenemase producing enterobacteriaceae infection (CPE). The closures were to ensure that infections were contained and not spread onto other wards. At the time of the inspection the cardiology ward was closed due to CPE. CPE was on the trust risk register with actions identified to mitigate the risk. CPE are bacteria which can live in the gut of

humans and animals. At times CPE are harmless and there are no signs or symptoms because a person's immune system keeps them in check. If they get into other parts of the body e.g. the urine or the blood, they can cause an infection and will need treatment. The trust were working closely with Public Health England to help generate the evidence base for national and international guidelines for controlling CPE and other antibiotic resistant organisms.

- There were sufficient hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal Protective Equipment (PPE) such as aprons and gloves were readily available and in use in all areas.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.
- We observed a patient who had MRSA being nursed in the main bay area as there was no side room available. The infection prevention nurse undertook a risk assessment to ensure the patient was nursed in the most appropriate way until a side room became available.
- Cleaning schedules had been completed as required and notices were seen on doors to the wards when an area was due to be deep cleaned. Staff used disposable mops to clean the floors to reduce the risk of cross infection. Cleaning storerooms were generally clean and tidy.
- Infection, prevention and control audits and hand hygiene audits were carried out on a regular basis on each ward. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff, for example a reminder was sent to staff to ensure there was an extra focus on hand washing before and after patient contact. Compliance levels across the wards were mostly good.

Environment and equipment

- The wards and areas we visited were well maintained.
- There were systems in place to maintain and service equipment. Regular portable appliance testing had

Medical care (including older people's care)

been carried out on the majority of electrical equipment and electrical safety certificates were in date. Hoists had been serviced appropriately. However there were a number of medical devices that had out of date electrical safety certificates on ward AM1. This included medication pumps and an ultrasound machine. This was brought to the attention of senior staff who assured us this would be rectified before the equipment was used.

- Resuscitation equipment was available on all the wards we visited. Resuscitation equipment trollies were locked apart from those on ward 27 and ward 31. We did not see any tamper seals in place on all of the wards we visited which meant there was a risk that equipment could be removed and therefore may not be available when needed. Emergency drugs were available and within the expiry date. Checks of the equipment had been completed on a regular basis.
- On AMU and ward AM1 there were oxygen cylinders stored in communal areas that were not secure and were accessible to the public. 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.
- The lock to the main door on the room used to store clinical waste on AM1 and AM2 was broken. Department of Health guidance on the safe management of healthcare waste (HTM 07-01) states: "Storage areas at the point of production (that is, patients' rooms) should be secure and located away from public areas." This meant there was a risk that clinical waste could be accessed by patients and the public which presented a risk of harm. Senior staff assured us this would be raised with the maintenance department to get the door mended.
- Results from the Patient Led Assessments of the Care Environment (PLACE) in 2014 showed ratings from 95% to 97% in services across the trust for condition, maintenance and appearance.

Medicines

- All wards had safe systems for the storage, handling and disposal of medicines. Staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. We reviewed a sample of stock balance records for controlled drugs and found they were correct. Two nurses checked the doses and

identified the patient before medicines were administered. Daily checks of controlled drugs balances were recorded as outlined in the trust's policy. However on ward AM2 during October 2015 these checks had not been carried out on eight occasions.

- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Fridge temperatures were checked daily on the majority of the wards we visited. However, on ward AM4, ward 46 and AMU we saw instances where the temperature had been outside the normal range and no action had been taken. On questioning, some staff did not know how to reset the thermometer to check the fridge temperature range.
- All medicines on the wards we visited were in date indicating there were good stock management systems in place.
- We looked at 38 sets of medication records. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- Antibiotics, for patients who required them, had all been prescribed in line with guidance.
- Between August 2014 and August 2015 there had been 515 medication errors reported in medical services across the trust. 277 were due to administration errors. The majority had resulted in no harm and five had resulted in low harm. 122 were due to prescribing errors and three of these resulted in moderate or low harm. All had been investigated and appropriate action taken.
- Patients were not routinely assessed for their ability to self-medicate. We saw an example of one patient on AM4 who had taken their own medicines but nursing staff were unaware and had also administered medicines to them. This was raised at the time of the inspection with the nurse in charge who looked into the incident. We were assured that the medicines were not high risk medication. However, there was no assessment or documentation for self-medicating as per the trust policy.
- There was a lack of information and guidance for nurses when administering some 'when required' medicines with variable doses. For example, on AM4 we saw a case where the nursing staff did not know what the medicine had been prescribed for and there was no information on the medication chart from the prescriber. On AMU a nurse told us they would have to contact the prescriber

Medical care (including older people's care)

to ask what dose to give for a particular patient as they were not comfortable with the dose range on the medication chart. There was a risk this could delay the medicine being given.

Records

- We looked at 34 patient records; they included a range of risk assessments and care plans that were completed on admission and reviewed throughout a patient's stay. Patients had an individualised care plan that was regularly reviewed and updated in the majority of the records we reviewed. However, we did see one patient who had been admitted to AMU at 06:15 am and had not had a nursing assessment completed when we visited the ward at 10:30 am. Staff told us this was due to nurse staffing levels being low that morning. However, records showed the patient had been reviewed by a doctor.
- In most areas records were not stored securely. Records were stored in unlocked trolleys or on shelves in patient bays. This increased the potential for patient confidentiality to be breached.
- In the majority of the records we looked at documentation was legible, signed and dated.
- Services undertook regular record keeping audits every three months. The last audit showed that patient number and the role of clinician making the entry were poorly recorded. Recommendations had been identified which included the use of patient stickers and clinician stamps.

Safeguarding

- There was a clear system for raising safeguarding concerns. Staff were aware of the process and safeguarding advice was accessible for staff 24 hours a day, seven days a week if they had safeguarding concerns.
- Training statistics provided by the trust showed that specialist medical services were below the trust target of 90% for safeguarding level 3 training and acute and community medical services were above the trust target. Trust wide compliance with safeguarding level 1 training was 83% and 76% for safeguarding level 2 training. The trust target was 80%.
- Safeguarding training was included in induction training for all agency staff before commencing work on the wards.

Mandatory training

- Staff received mandatory training on a rolling annual programme. The mandatory training was split into level 1 and level 2 training and was in areas such as health and safety, fire, manual handling, safeguarding and infection control and prevention.
- At the time of our inspection 74% of medical staff across the trust had completed level 1 training and 63% had completed level 2 training. Compliance rates for allied health professions, such as physiotherapists and occupational therapy, across the trust was 92% for level 1 training and 94% for level 2 training. The trust target was 90%.
- From the information the trust provided the compliance rate for other staff groups, including nursing staff, working in acute medicine (which included A&E) at the hospital was 78% for level 1 training and 69% for level 2 training. For other staff groups working in specialist medicine (which included critical care), 86% had completed level 1 training and 77% had completed level 2 training. The trust target was 90%.

Assessing and responding to patient risk

- An electronic early warning score system (EWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. The system linked hand held devices to the main patient record and the electronic board on the wards which was used to identify key information about patients.
- The trust undertook an audit of the EWS system in 2014. This identified areas of good practice and areas of improvement. An action plan was in place to improve standards. For example discussing with critical care consultants responses to high risk alerts to help improve response rates.
- 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 ulcers and nutrition (Malnutrition Universal Screening Tool or MUST).
- We reviewed 34 patient records and found that care plans were not always personalised but did contain the necessary information to ensure that patients were not at risk and care was managed safely.

Medical care (including older people's care)

- Medical services had safer standards in place to ensure that patient reviews and assessments were completed in the specified timeframe. We checked nine records on AMU to see if these standards were being met. The majority of the standards were being met although the standard that observations and early warning scores were to be documented within 15 minutes of arrival on the unit was difficult to check. This was due to arrival times on the unit not always being documented on the patient tracking system. Staff said this was sometimes documented in the nursing notes.

Nursing staffing

- Nurse staffing levels had improved. Matrons met regularly to discuss nurse staffing levels to ensure staff and skills were appropriately deployed and shared across all wards.
- Managers knew where there were shortfalls and where there was surplus on other wards so that staff could be called on if needed.
- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The trust used the National Institute for Health and Care Excellence (NICE) guideline: 'Safe staffing for nursing in adult inpatient wards in acute hospitals'. However not all wards were regularly using these recommendations to ensure safe staffing levels.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the 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.
- On the day we visited AMU, nurse staffing levels were not filled as planned. Instead of 10 registered nurses there were seven nurses on duty during the day. The ward manager was trying to find agency staff to help cover these shifts. Staff said the number of shifts not being filled as planned was a regular occurrence but they would only complete an incident report if the levels fell to seven nurses on duty. AMU is a 54 bedded unit for patients who normally require a high level of care.
- We looked at staffing levels for 10 medical wards between June 2015 and August 2015. The average percentage of nursing shifts filled as planned during the day was variable. Of particular concern were wards AM1 at 79%, AM2 at 80%, AMU at 82%, ward 45 at 82% and ward 5 at 76%. The fill rates for the remaining five wards were at 90% or over.
- The average percentage of nursing shifts filled as planned during the night between June 2015 and August 2015 was also variable. Only two wards were over 90%. Of particular concern were wards AM1 at 77%, AM2 at 80%, AMU at 81%, ward 14 at 72%, ward 45 at 72%, ward 46 at 76% and ward 5 at 64%.
- Staffing levels on the endoscopy unit were low at the time of the inspection which had resulted in a number of treatment rooms being closed. This had had an impact on the waiting list and on maintaining patients' privacy and dignity. At times, this meant, the unit was unable to facilitate single sex bays.
- Services tried to use the same bank and agency staff to ensure they had the required skills to work on the ward. Agency staff were given an induction before commencing work on the wards.
- There were 575 nurse vacancies across the trust in August 2015. This number had reduced to 489 by November 2015. The turnover rate of nursing staff was variable, for example the rate for ward 30 was 37% and AMU was 17% for the last 12 months.
- Nurse staffing was on the trust risk register and on the medical care divisional risk register. Actions had been identified to mitigate the risk. These included the implementation of the retention strategy, daily reviews of staffing levels and a comprehensive recruitment programme.
- Wards allocated at least one qualified nurse to each bay to get to know the patients and provide a constant presence within the bay.
- We saw effective handover meetings between nursing staff which highlighted key risks. There was a checklist to help ensure all relevant information was shared with staff. This included deteriorating patients, falls, infection control issues and staffing.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across the wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing on the medical care wards was appropriate at the time of the inspection.

Medical care (including older people's care)

- Patients reported that they did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends should patients need to see a doctor. Ward rounds did not take place on every ward at weekends, for example AM3 and AM4. Consultant cover was available on site from 8am to 9pm daily and a physician was on call outside these hours. There was an acute medical consultant on call who could get to the hospital within 30 minutes in an emergency.
- The percentage of consultants working in medical services at the hospital was 42% which was higher (better) than the England average of 34%. The percentage of registrars was 41% which was higher (better) than the England average of 39%. The percentage of junior doctors was 10% which was lower (worse) than the England average of 22%. Middle grade levels were about the same as the England average.
- Due to vacancies, there was no designated AMU consultant. There were plans to advertise this internally as staff had expressed an interest in the post but there was no timeframe for this action. In the interim, cover was provided by the clinical director of acute medicine.
- In July 2015, there were 38 medical staff vacancies across the trust. At the time of our inspection there were still a number of ongoing vacancies.
- The use of locum medical staff across the trust from April 2014 to March 2015 was variable. In haematology services it was low at 3.7% but in acute medicine 25% of shifts were filled by locum staff.
- We saw an effective ward round which included an advanced nurse practitioner to ensure that any actions identified were implemented and that information was available for the doctors.

Major incident awareness and training

- There were documented major incident plans within medical care 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.
- Staff in medical care services had been involved in major incident simulation exercises.

Are medical care services effective?

Good



We rated medical care services as 'Good' for Effective because;

Care was provided in line with national best practice guidelines and medical care services participated in the majority of clinical audits where they were eligible to take part. National audits indicated that the majority of patients experienced good outcomes. Improvements had been made in the provision of stroke care although some improvements were still required. Action plans were in progress where areas for improvement had been identified. There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

Staff understood the key principles around obtaining informed consent, the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). However DoLS paperwork could be variable, particularly in relation to emergency applications.

A gap analysis was underway to identify what actions were required to develop further seven day services. Most staff said they were supported effectively. Junior staff felt well supported and received a full induction. Healthcare support staff were supported to complete national competency based training to ensure they had the relevant skills to undertake their role. However, the number of staff in the medical services division who had received their annual appraisal was below the trust target.

Evidence-based care and treatment

- Medical care services used national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified.
- The service participated in all but four of the clinical audits for which it was eligible through the advancing quality programme. In March 2015, audits demonstrated

Medical care (including older people's care)

the trust was not meeting the appropriate target in a number of areas. For example, chronic obstructive pulmonary disease and heart failure. The service had actions plans in place to improve performance.

- The hospital had ambulatory care pathways in place for managing patients who had cardiac chest pain, acute severe headaches and atraumatic swollen lower limb. These were based on best practice guidelines. Ambulatory care is medical care provided on an outpatient basis.
- There were examples of recent local audits that had been completed on the wards. These included cleanliness, documentation and nutritional screening audits. 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 regularly monitored for efficacy. Patients told us they were consistently asked about their pain and supported to manage it.
- We did not see evidence that there were any specialised tools in place to assess pain in those who had a cognitive impairment such as dementia or a learning disability.

Nutrition and hydration

- A coloured tray and jug system was in place to highlight which patients 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. However a number of patients on ward 27 told us their hot meal was often cold. The standard of food was an identified risk on the trust's risk register and a programme of work was being undertaken to understand where and what improvements were required.
- We looked at the kitchen facilities and found these to be adequate. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack bag for them.
- On ward 45, we observed that the dietician was present during the mealtime. This was to observe patients eating to see if they required any additional support, for example special equipment or referral to an occupational therapist.

- Fluid balance charts were mostly fully completed and records showed that patients had had an assessment of their nutritional needs and were referred to a dietician where necessary.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14, showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI - a type of heart attack) seen by a cardiologist prior to discharge was better than the national average at 100%. (The national average was 94%). However, 28% of patients with an N-STEMI were admitted to a cardiology ward. This was worse than the national average of 55%. The percentage of patients who were referred or had an angiograph (an investigation that looks into the blood vessels of the heart) was 89% which was better than the England average of 78%.
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service had made improvements in the care and treatment of patients following a stroke. The latest audit results for October – December 2014 rated the hospital overall as a grade 'D' (with 'A' being the best score and 'E' being the lowest). This was an improvement on the grade 'E' the service had previously achieved. The trust had an action plan in place to continue to improve performance against the standards.
- The 2012/2013 heart failure audit showed the hospital performed better than the England average for three out of the four clinical (in hospital) indicators and in all of the seven clinical (discharge) indicators.
- Medical services participated in the joint advisory group on GI endoscopy (JAG) and were JAG accredited. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. The unit was due for reaccreditation in 2016 and there was an action plan in place to improve the quality of the patient experience. This included receiving an appointment for an endoscopy as quickly as possible.
- In the national diabetes inpatient audit 2013, the trust scored worse than the England average for 12 of the 22 indicators and better than the England average for nine

Medical care (including older people's care)

of the 22 indicators (data was not available for one indicator). The trust performed better in the number of foot risk assessments completed within 24 hours and staff knowledge and emotional support offered to patients. Areas identified for improvement included: Percentage of patients seen by the multidisciplinary team within 24 hours and enabling patients to take control of their diabetes care.

- Between January 2014 to December 2014, hospital episode statistics(HES) showed that the average length of stay for elective medicine at the hospital was longer (worse) than the England average at 5.7 days. (The England average was 4.5 days). For non-elective medicine it was also longer (worse) than the England average at 9.3 days. (The England average was 6.8 days).
- The readmission rates for the hospital were worse than the England average in gastroenterology, and general medicine but better than the England average in haematology and nephrology. Cardiology was better than the England average for non-elective admissions but worse than the England average for elective admissions.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures at the end of March 2015, 77% of medical staff trust wide and 82% of allied health professionals had received their annual appraisal. 83% of other staff groups (including nursing staff) in specialist medicine and 59% in acute medicine (including A&E) had received their annual appraisal. The trust target was 85%.
- Staff told us there was no formal system for clinical supervision. However, nurses told us they did have regular meetings with their manager and they were able to speak to their manager at any time. 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. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- There was a preceptorship programme which supported junior nursing staff. Competency in care procedures were assessed by higher level qualified staff.
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy. Cadet nurses

were undertaking a national vocational qualification (NVQ) in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.

- The trust also participated in the pre-employment programme with the skills for health academy which gave local unemployed people the opportunity for work experience and to undertake training at the hospital to increase skills and experience. This had resulted in a number of people becoming permanently employed as nursing assistants in medical care services at the hospital.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications; however there was no service overview of which staff had gained qualifications.
- Healthcare support workers undertook the care certificate course. 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. Since June 2015, medical care services had supported eight nursing assistants to complete the care certificate and seven were currently undertaking the course.
- Staff confirmed they had received an adequate induction. Newly appointed staff said their inductions had been planned and delivered well.
- We saw a good example of how services ensured staff received the required training on the endoscopy unit. There was a quarterly training plan for staff including management of patients with a gastrointestinal bleed and a multi professional fortnightly forum, led by a registrar or consultant, to discuss different types of therapies for patients.

Multidisciplinary working

- Multidisciplinary team (MDT) working was well established on the medical wards. MDT meetings took place weekly and were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist.
- Meetings on bed availability were held up to four times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff.

Medical care (including older people's care)

- We observed handovers, which included healthcare assistants, nurses and medical staff. There was effective communication and they were well structured.
- Daily ward meetings called board rounds were held on most of the wards we visited. They reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed a board round and saw that it was well attended by a range of professionals.
- Ward teams had access to the full range of allied health professionals and 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

- A gap analysis was underway to identify what actions were required to develop further seven day services.
- A seven day service engagement event was held in July 2015 for all clinical staff across the trust. The aim of the event was to support medical services and other services to work together to develop seven day services.
- Diagnostic services were available 24 hours a day, seven days a week. However staff reported there were difficulties in getting endoscopy investigations due to capacity.
- Consultant cover was available on site from 8am to 9pm seven days a week.
- The rapid discharge team was set up to work seven days a week though this did not always happen due to low staffing levels at weekends.

Access to information

- All 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 and protocols were kept on the hospital's intranet which meant all staff had access to them when required.

- On the majority of wards there were files containing minutes of meetings, ward protocols and learning from incidents and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knew the principles of consent and we saw written records that consent had been obtained from patients prior to procedures.
- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- Information provided by the trust showed that 83% of staff trust wide had completed mental capacity act level 1 training and 76% had completed level 2 training. The trust target was 80%.
- However, staff were not always following the key principles when using bed rails for patients. Staff we spoke to on the wards did not know that the use of bed rails is seen as a form of restraint in the National Medical Council code of practice. The bed rails assessment did not include the recording of consent or best interest decisions for the use of bed rails, though did outline the principles.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). The 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. We saw examples of DoLS paperwork but the completion was variable.
- For example on the acute medical unit, two emergency DoLS applications had been completed on the wrong forms and had not been signed by the matron as outlined in the trust policy. Also the full procedure had not been completed for four emergency DoLS applications. This meant that patients were at risk of being inappropriately restricted. When we brought this to the attention of the matron, they immediately ensured the correct forms were completed and the applications resubmitted.
- Staff said that the trust was in the middle of implementing a new electronic system and policy and they had not yet had the training, though this was planned before the end of 2015.

Medical care (including older people's care)

Are medical care services caring?

Good



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

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained

Patients were involved in their care, and were provided with appropriate emotional support. The Friends and Family Test (FFT) showed the majority of patients who responded would recommend the service to their friends or relatives. FFT response rates however, were slightly worse than the national average.

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect.
- All the patients we spoke with were positive about their care and treatment. One patient told us that staff responded when needed. One patient said that if they had to suggest anything to change it would be to have access to Wi-Fi.
- Patients said that staff always introduced themselves.
- The friends and family test (FFT) average response rate for the hospital was 30% which was lower than the England average of 36%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. Results showed that the majority of patients who responded would recommend the medical care services to their friends and relatives. For example, between July 2014 and June 2015 wards AM2, 4 and 46 scored 100% on seven or more occasions. In September 2015 wards 44 and 31 scored 100%.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts in five of the 58 areas. These included 'patient given the choice of different types of treatment' and 'patients given the name of the clinical nurse specialist in charge of their care'. The trust performed in the

bottom 20% of all trusts in 17 of the 58 areas including 'staff did everything to control side effects of chemotherapy'. The trust performed the same as the other 60% of trusts in the remaining 36 areas.

- We saw that the majority of people had access to call bells and staff responded promptly. However on AMU four of the calls bells in a six bedded bay were not in reach for the patients. We raised this with staff at the time of our inspection and action was taken immediately to rectify the situation.
- The trust performed 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.
- 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 had a named nurse and consultant. Patients were aware of this and they were displayed on a board above the bed.
- Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients told us they felt safe on the ward and had received orientation to the ward area on admission.
- All patients we spoke with said they had received good information about their condition and treatment.
- One of the wards we visited had introduced evening snacks following patient feedback that there was a lack of snacks between meals. They had also introduced the initiative of putting a notice on patient bedrooms reminding people to knock before entering.

Emotional support

- Some staff said they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant this did not always happen.
- Visiting times met the needs of the patients with whom we spoke. Open visiting times were available if patients needed support from their relatives.
- Chaplaincy services were available for patients 24 hours a day, seven days a week.
- There was also a multi-faith centre that provided a quiet space for reflection and peace.

Medical care (including older people's care)

Are medical care services responsive?

Good



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

Medical services met the 18 week standards for referral to treatment times in all specialities from September 2013 to July 2015. Patients were sometimes placed on wards that were not best suited to meet their needs (also known as outliers). However, there were good systems in place for the management of these patients to ensure they received a regular medical review.

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. The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not scheme for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. There was access to translation services and leaflets were available for patients about the services and the care they were receiving.

However, there were high bed occupancy levels on the wards. There were a number of patients who were moved during the night on some wards and half of all patients experienced one or more moves during their stay. There was a clear focus on discharge planning although there were a number of patients experiencing delayed discharge because they were waiting for packages of care and could not be discharged until funding for this care had been agreed. Patients' privacy and dignity was not always maintained on the endoscopy unit as there were male and female patients in hospital gowns in the same waiting room with only a temporary screen to separate them. Plans were in place to address this.

Service planning and delivery to meet the needs of local people

- Medical services had a designated ambulatory care unit. This unit saw patients on an outpatient basis for further tests to avoid unnecessary admission.
- The hospital was part of the heathier together programme to reconfigure services across Greater Manchester into a small number of specialist centres to help meet the needs of patients.
- Patients' privacy and dignity was not always maintained on the endoscopy unit. This was due to low staffing levels impacting on the ability to run single sex bays. At the time of the inspection it was observed that male and female patients were sitting in a waiting area segregated by a small temporary screen. A business plan had just been approved to refurbish the unit which would ensure this issue was addressed. Staff said this was due to commence before the end of March 2016.

Access and flow

- Medical services met the 18 week standards for referral to treatment times in all specialities from September 2013 to July 2015.
- The bed occupancy rate on the medical wards at the time of the inspection was above 90%. Between April 2015 and September 2015 the occupancy rate was between 91% and 96%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed there was a shortage of medical beds and a number of patients were placed on wards that were not best suited to meet their needs (also known as outliers). Between April 2015 and September 2015, data showed there had been 959 medical outliers at the hospital. At the time of our inspection there were 14 medical outliers.
- Patients who were outliers were reviewed on a daily basis by a member of the medical team. We reviewed the records for four medical patients who were outlying on the emergency surgical trauma unit, 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. There was a standard operating procedure for outlying patients which was being followed.
- The hospital held bed management meetings regularly throughout the day during the week to review and plan

Medical care (including older people's care)

bed capacity and respond to acute bed availability pressures. Ward liaison officers supported these meetings by providing up to date information on ward capacity.

- During the period August 2014 to July 2015, 55% of patients experienced multiple moves during their stay. This was the same as the previous year. The patient transfer policy stated that patients should not be transferred between 10pm and 7am unless in exceptional circumstances. Information provided by the trust showed that between February 2015 and July 2015, 41 patients had been transferred from ward 36 during the night, 34 had been transferred from ward 37 and 11 had been transferred from ward 44. The information did not show the reasons why these moves had taken place during the night.
- Staff on ward 30 said that patients often stayed on the ward for long periods of time although the function of the ward was for short stay patients. There were no set criteria for admission to the ward (which was a 10 bedded area) from the emergency department. At the time of the inspection one patient had been there for 59 days, 1 patient for 21 days, and 1 patient for 19 days. Staff said this impacted on the flow of patients.
- There was a clear focus on effective discharge planning for patients and wards. Staff discussed discharges at the daily board round and at the bed management meeting. Discharge letters were sent to general practitioners and patients were given a copy. There were discharge managers allocated to medical wards to support the process.
- There was a discharge team who supported patient discharges which were complex or required rapid discharge. Discharges were often delayed due to waiting for care packages or for equipment that was needed in the home (27%). The team included a paramedic, a social worker and a physiotherapist.
- Staff said that at the time of the inspection, there were 14 delayed discharges across medical services. This meant that there were 14 people in hospital that didn't need to be.
- There were plans under development to transfer patients to Trafford General Hospital whilst awaiting discharge and meetings were taking place with the local authority to ensure patients who were fit for discharge were discharged as quickly as possible.
- The trust had a discharge lounge which operated between the hours of 8am and 8pm seven days a week.

The lounge was managed by one nurse. They were unable to accept patients who required a bed or any patient from the wards after 6pm. There were good facilities, which included hot meals, and a garden space.

- There was a new early supported discharge service for stroke patients which includes therapists and nurses.

Meeting people's individual needs

- The trust used a tree symbol to indicate that a patient was frail or elderly and a flag symbol to indicate that a patient had a learning disability. 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 discrete 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.
- There was a clinical lead for dementia who provided support for staff and acted as a central point of contact for queries. The service had developed a dementia strategy. There were core groups looking at what was required for the implementation of the strategy, for example improving the patient journey and caring for carers.
- Between April 2015 and July 2015, 428 staff had received dementia awareness training and for staff who were dementia champions, study days were available in partnership with a local university.
- Medical services did not have access to a psychiatric liaison team to see and assess appropriate patients with a cognitive impairment. However, staff said there had been a number of successful meetings with partners to identify funding for psychiatric input to support these patients.
- We observed the use of security staff, when nursing assistants were not available, to support patients with dementia who had challenging behaviour. Senior management staff said they were looking at putting in place alternative arrangements to support dementia patients, but no definite plans or date were known. Security staff had received training in physical intervention but had not received any specific dementia awareness training.
- Key carers were given a card which allowed them 24 hour access to the ward to visit and support relatives.

Medical care (including older people's care)

- Patients with a learning disability were supported when having an endoscopy. Staff told us how they made reasonable adjustments such as a quiet room or specific supported appointments, although JAG regulations limited relatives being with them during the procedure.
- 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 other languages for patients if required; and in an accessible format for people living with dementia or learning disabilities.
- There was a range of specialist nurses, for example for dementia, chest pain and diabetes, who offered specialist advice to staff caring for people with these conditions. Staff told us they knew how to contact these specialists and felt supported by them.

Learning from complaints and concerns

- People knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- There were leaflets and information available on all the wards we visited explaining the complaints procedure and how to access the Patient Advice and Liaison Service (PALS)
- Staff were aware of the trust's complaints system and how to advise patients and those close to them if they wanted to make a complaint.
- Senior staff told us how they were now working to achieve 'on the spot' resolutions of concerns where possible.
- Medical services had seen a reduction in the number of complaints from 275 in 2013/14 to 220 in 2014/15.
- Learning from complaints and concerns was disseminated via team meetings. Examples of learning included additional patient rounds to specifically check if they had any worries or fears and a review of pathways in the endoscopy unit.
- Wards also displayed the compliments they received. Following a compliment received from a carer of a patient who had a learning disability, their experience was filmed and shared across other services in the trust which provided the opportunity for staff to learn from the experience.

Are medical care services well-led?

Good



We have rated medical care services as 'Good' for Well-led because;

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 effective communication within staff teams.

A ward accreditation scheme was in place and the service undertook regular care quality assessments across all ward areas and action plans had been put in place to improve performance. Staff felt supported and able to speak up if they had concerns. Medical services captured views of people who used the services with learning highlighted to make changes to the care provided. 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.

Risk registers were in place and included control measures and the actions that had been taken to minimise the impact of identified risks. However, there were risks without any actions identified and there was limited evidence that the risk register was routinely monitored as part of key meetings across all medical services.

Vision and strategy for this service

- The trust's vision was underpinned by the values of pride, dignity, empathy, respect, consideration and compassion. Staff at all levels within medical care services at the Manchester Royal Infirmary referred to this behavioural framework.
- Trust strategic objectives were based on this vision and these objectives were cascaded down to individual objectives for staff.
- Medical care services had business plans in place which identified challenges and objectives. For example infection control and improving learning from patient feedback. The plans also identified actions to meet the objectives.

Medical care (including older people's care)

- Services also had strategies and plans in place for key areas. For example, operational workforce, kidney care, dementia and clinical haematology.

Governance, risk management and quality measurement

- For governance purposes, medical care services at the MRI sat within two divisions. Acute medical services sat within the Division of medicine and community services whilst specialist medical services sat within the Division of specialist medicine.
- The risk register highlighted risks across all medical services at the trust and actions were in place to address concerns, for example lack of staff on the renal unit. However, from the information provided by the trust there were risks on the register without any actions identified to mitigate the risk. For example, staff not being trained in de-escalation techniques to manage situations appropriately so that patients and staff were not at risk from violence and aggression. Another example was the risk that bronchoscopes were not being maintained and replaced resulting in cancelled appointments. This meant it was not clear whether all risks were being managed as effectively as possible.
- 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 acute medical services and the acute medicine and community services divisional management board meeting was held on a monthly basis. During the meeting there was a review of items to celebrate good practice and items of concern. There was also feedback from other key meetings, for example the quality update and performance update.
- However, it was unclear from the minutes we reviewed, if there had been any discussion or review of the risk register, incidents and complaints. It was also unclear if any learning had taken place to be shared with staff. Actions from the meeting were identified in the minutes along with the person responsible but there was no target date for the actions to be completed. It was therefore difficult to track what progress had been made against agreed actions.
- Information provided at the time of the inspection showed that specialist medical services had an integrated governance framework for 2015/16 which showed the governance reporting structure for key

meetings held in the service. This clearly identified a patient safety and governance board. We asked for minutes of this meeting to review but no evidence had been forwarded to us.

- A specialist medical services divisional board meeting was held on a monthly basis. During the meeting patient stories were heard to improve care and the overall medical services risk register was discussed. However, the minutes of the meeting did not provide a clear and accurate account of what was discussed.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.
- A ward accreditation scheme was in place and so regular care quality assessments were carried out across all wards. These included assessments on the environment, care and leadership. Each ward was assessed and then awarded either a gold, silver or bronze standard. Action plans were put in place following each assessment to improve standards. Services were using this accreditation scheme to drive quality improvement.
- Ward 45 had recently been awarded the quality mark for dementia care from the royal college of physicians.

Leadership of service

- Staff reported there was clear visibility of the trust's board throughout the service. Staff could explain the leadership structure within the trust and within medical services. 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 that morale was good.
- In the 2014 staff survey, 95% of staff at the trust said they were enthusiastic about their job and 86% looked forward to going to work.
- Staff said there was a positive culture around challenging decisions by other staff. For example, if a

Medical care (including older people's care)

doctor stated that a patient was ready for discharge and a nurse did not feel it was appropriate, they said they would feel comfortable discussing this further with the doctor to ensure the patient received the correct care.

Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The acute medicine and community services divisional monthly board meetings included a patient story to highlight patients' experiences of using the hospital's services.
- Services used an electronic system to obtain feedback from patients on a regular basis whilst at the hospital, this included feedback on the meal that had just been provided, how staff were managing patients' pain, did they give patients privacy and dignity and did patients feel safe in the environment. Each ward's performance was then monitored to ensure the level of care and services provided improved.

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.
- Services held 'cake, coffee and chat' meetings on a monthly basis for staff to discuss any issues with senior managers.

- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development. 65% of staff in the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 66% felt it had helped them to do the job more effectively. 45% felt that they were valued by the organisation. This was worse (lower) than the national average of 62%.
- The trust undertook a 'pulse survey' with staff in August 2015 which showed that 77% would recommend the trust as a place to receive treatment and care. 59% would recommend the trust as a place to work. 1382 members of staff responded to the survey.

Innovation, improvement and sustainability

- Services were working with the provider for agency and bank staff to begin a night clinical support worker pool for acute medicine. This would ensure that there was an adequate number of support staff available for areas where they were needed most.
- Medical services had created and developed an IT system to support the timely management of discharging patients. This had since been rolled out across the trust. This had been successful in reducing the length of stay for patients.
- Medical services were undertaking a six month pilot with a neighbouring mental health trust, to undertake daily reviews of patients who had an alcohol dependency. This would be evaluated to inform future plans.

Surgery

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

Information about the service

The Manchester Royal Infirmary provides a range of elective and unplanned surgical services, including trauma and orthopaedics, ear, nose and throat (ENT) surgery, maxillofacial surgery, urology, cardiac surgery, renal transplant surgery, vascular surgery and general surgery (such as hepatobiliary, colorectal and gastro-intestinal surgery).

The hospital has 11 inpatient surgical wards, a day case unit and 18 operating theatres, including 12 theatres in the main suite and six theatres in the elective treatment centre. The elective treatment centre also has two hybrid theatres that are mainly used for vascular surgery. Hospital episode statistics data showed that 45,102 patients were admitted for surgery at the trust between January 2014 and December 2014. The data showed that 27% of patients had day case procedures, 27% had elective surgery and 46% were emergency surgical patients at this hospital.

Manchester Royal Eye Hospital (MREH) is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the trust's main site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a large, specialist ophthalmic teaching hospital. The hospital provides a range of elective and unplanned ophthalmology surgical services including: emergency eye surgery, ophthalmic imaging, ultrasound, macular treatment, cataract surgery, electro-diagnosis, laser vision correction surgery, optometry, orthoptics, bionic eye implants and ocular prosthetics.

The hospital has an inpatient surgical ward (ward 55) with 17 beds and eight additional beds that are used as a surgical admissions lounge. There is an additional inpatient ward (ward 54) with four beds for private patients and five operating theatres, including a dedicated children's theatre. There is a day case unit (eye J) including a pre-operative assessment area, six examination rooms, three interview rooms and a number of specialist treatment rooms. The macular treatment centre is also located in the day case unit. This has two injection rooms, clinical imaging facilities and seven examination rooms.

We visited Manchester Royal Infirmary (MRI) and Manchester Royal Eye Hospital as part of our announced inspection during 4 to 6 November 2015. We also carried out an out-of-hours unannounced visit on 26 November 2015.

As part of our inspection of MRI, we visited the main and elective theatres, the elective treatment centre (including the day case and short stay unit), the pre-assessment unit, the emergency surgical trauma unit (wards 1 and 2), the vascular and head and neck unit (ward 7), the hepato-pancreatico-biliary (HPB) ward (ward 8), The renal transplant and urology unit (wards 9 and 10), the general surgical wards 11 and 12 and the carbapenemase-producing enterobacteriaceae (CPE) isolation ward (ward 14).

As part of our inspection of MREH, we visited the theatres, inpatient wards (ward 54 and 55), the surgical admissions lounge, the day case unit and the macular treatment centre.

Surgery

In total, we spoke with 14 patients. We observed care and treatment and looked at 10 care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, health support workers, porters, domestic staff, housekeepers, matrons, theatres staff and the clinical head of division, the divisional head of nursing, the associate divisional directors and the divisional director for the division of surgery. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Summary of findings

We have rated surgical services as 'Good' overall because;

There were sufficient numbers of consultants and medical staff to provide patients with safe care and treatment. There were still a high number of nursing vacancies in the wards and theatre areas at Manchester Royal Infirmary. However, staffing levels were maintained through the use of existing staff working overtime and with agency staff. There were plans in place to recruit 60 whole time equivalent nurses through EU and international recruitment by January 2016. This was in addition to the planned recruitment of approximately 150 staff from the trust's domestic recruitment programme. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean and suitably maintained premises.

Surgical services provided effective care and treatment that followed national clinical guidelines and participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. 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. Patients spoke positively about their care and treatment and they were treated with dignity and compassion.

The surgical services achieved the 18 week referral to treatment standards across all specialties. There were systems in place to support vulnerable patients. However, elective operations were frequently cancelled due to the lack of available beds and theatre lists running late. The rate of cancelled elective operations was higher than the England average since July 2014. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between October 2014 and June 2015 but was showing improvement by quarter 3 2015/16 (October to December). The division of surgery transformation plan included improvement actions to improve theatre efficiency and reduce

Surgery

cancelled operations. There was sufficient capacity in the MREH to ensure patients admitted for surgery could be seen promptly and receive the right level of care. The rate of operations cancelled at this hospital was low and within expected levels.

The trust vision and values had been cascaded across the surgical wards and departments and staff had a clear understanding of what these involved. The wards and theatres had clearly visible leadership with clinical, nursing and business leads. Most staff were positive about the culture and support available. Monthly clinical effectiveness meetings reviewed incidents, key risks and monitoring of performance. There was routine public and staff engagement and actions were taken to improve the services.

Are surgery services safe?

Good



We rated surgery services 'Good' for Safe because;

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. Staff monitored patients by using an electronic early warning score system that automatically notified medical staff if there was deterioration in a patient's medical condition.

There were sufficient numbers of consultants and medical staff to provide patients with safe care and treatment. There were 72.5 whole time equivalent nursing vacancies in the wards and theatre areas at MRI. However, staffing levels were maintained through the use of existing staff working overtime and with agency staff. There were plans in place for the MRI to recruit 60 nurses from the European Union and internationally between the time of our inspection and the end of January 2016. This was in addition to the planned recruitment of approximately 150 staff from the trust's domestic recruitment programme. Staff received mandatory training in order to provide safe care. However, the numbers of staff that had completed mandatory training was below the hospital's expected levels.

Incidents

- The strategic executive information system data showed This included three patient deaths, one incident relating to sub-optimal care of the deteriorating patient, three grade three pressure ulcers, three grade four pressure ulcers, one incident relating to delayed treatment, one patient fall and an incident relating to kidney transplantation where the transplanted kidney was removed due to blood clot. We saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care.
- There had been one never event reported in surgery services. Never events are serious, wholly preventable

Surgery

incidents that should not occur if the available preventative measures had been implemented. The incident related to wrong site surgery. The incident had been fully investigated.

- Trust data showed there no serious incidents reported to the strategic executive information system data in relation to ophthalmology surgical services at MREH between August 2014 and July 2015.
- There had been two 'never events' relating to the ophthalmology surgical services at MREH since December 2014. A 'never event' is a serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The two never events related to the wrong strength of lens being inserted. One incident occurred at this hospital in September 2015.
- Remedial actions had been taken to minimise the risk of recurrence of these never events. Theatre staff had previously written the strength of the implant on a white board and the previous patient's lens details had not been erased, which contributed to the surgical error. The theatre staff told us this practice no longer took place. The surgical checklists were also updated to introduce an additional step for the surgeon and nurse to both carry out additional checks prior to commencing surgery.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by a multidisciplinary team of trained staff with the appropriate level of seniority, such as divisional and directorate level nursing and clinical leads.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. Learning from incidents was shared at monthly staff meetings and on staff notice boards in resource areas on the wards.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. 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.

- Patient deaths were reviewed by individual consultants within their surgical specialty area. These were also presented and reviewed at monthly divisional mortality meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month such as falls, pressure ulcers, venous thromboembolism (VTE - the formation of a blood clot in a vein), catheter and urinary infections.
- Safety Thermometer information between July 2014 and July 2015 showed that surgical services across the trust performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers. The data showed there had been six pressure ulcers, two catheter acquired urinary infections and no falls reported during this period.
- Information relating to the Safety Thermometer performance was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections or Clostridium difficile (C. diff) infections relating to surgery at the Eye Hospital during the past year.
- There had been no MRSA bacteraemia infections, 11 Clostridium difficile (C.diff) infections and two carbapenemase-producing enterobacteriaceae (CPE) bacteraemia infections relating to surgery at the MRI between April 2015 and the end of October 2015. CPE are bacteria which can live in the gut of humans and animals. At times CPE are harmless and there are no signs or symptoms because a person's immune system keeps them in check. If they get into other parts of the body e.g. the urine or the blood, they can cause an infection and will need treatment.
- We looked at the investigation reports and action plans for a C.diff incident and a CPE incident that occurred on ward 8 (during April 2015 and June 2015. These showed that both incidents had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team. Remedial actions included additional monitoring of staff in relation to adherence to aseptic non-touch technique and hand washing practices.
- There was a dedicated isolation ward (ward 14) for treating surgical patients that were identified with CPE

Surgery

infection at the hospital. The isolation ward had 20 inpatient beds and included dedicated staff and equipment to treat patients with CPE infections and minimise the risk of the spread of infection.

- All patients admitted to the surgical wards were screened for MRSA. Patients identified at risk were also screened for CPE infections so they could be promptly isolated and treated to minimise the risk of spread of infection.
- Records showed the surgical site infection rates for hip and knee surgery at the hospital were within the national averages between January 2015 and March 2015.
- The wards and theatres we inspected were visibly clean. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was access to hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- A hand hygiene audit carried out in May 2015 showed overall compliance by staff across the division of surgery was 68% (159 out of 233 staff adhered to hand hygiene guidelines). This was below the trust's expected level of compliance (95% or above).
- An action plan was in place to improve hand hygiene compliance by raising staff awareness and providing additional training. Monthly hand hygiene audits were carried out to monitor staff adherence to hand washing guidelines. Where staff failed to adhere to hand hygiene guidelines, they were identified and spoken with on an individual basis. A further audit was scheduled for January 2016 to check whether improvements had been made.
- A hand hygiene monitoring and improvement system was being trialled on a number of surgical wards. This system was based on a badge worn by staff that monitored hand hygiene activity and gave a colour-coded indicator to show the current level of hand hygiene status for that individual. For example, a green indicator meant hands were clean and staff could make

patient contact whereas a red indicator meant the staff should clean their hands. The process was being trialled to check its effectiveness with a view to roll out across the trust if it was successful.

- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- The main theatre areas at the MRI were well maintained but were aged and in need of refurbishment. The staff change areas were small, restrictive and had an insufficient number of storage lockers for staff to use. There was a scheduled improvement plan in place to upgrade the capacity within the change rooms during 2016.
- The equipment we observed in the wards and theatre areas was visibly clean and well maintained. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Inventory records showed there was sufficient stock and availability of imaging equipment such as retinal cameras and microscopes. Staff raised requests with the maintenance team by phone and told us they received good and timely support. Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs.
- In the MRI, we found there was a sufficient number of anaesthetic machines and operating department practitioner.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit. Theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

Surgery

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately across most areas.
- Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures. However, in the elective treatment centre, some staff did not know how to operate the fridge thermometer; records showed there were some instances when the temperature had been outside the required range and it was not clear what action had been taken.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. Ward staff confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for nine patients and found these to be complete, up to date and reviewed on a regular basis. The medication charts also showed that oxygen given to patients was prescribed and documented correctly.
- At the MREH, surgeons prescribed medications for patients to take home following discharge. The ward-based doctors could prescribe any additional medication required for the patient to take home. Ward staff told us patient discharges were sometimes delayed if additional medications had been prescribed and had to be ordered from the pharmacy services.

Records

- Staff used paper patient records and these were securely stored in each area we inspected. An electronic records system (Chameleon) was also used by some services in the MREH and this allowed staff to access some patient clinical notes electronically.
- We looked at the records for 10 patients. These were structured, legible, complete and up to date. However, patient records at the MRI were often too bulky for the folder, which meant some records could become loose.
- Patient records included risk assessments, such as for falls, VTE, pressure care and nutrition. These had been reviewed and updated on a regular basis.

- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 94% of staff across the surgical division at the MRI had completed basic (level one) safeguarding training and 93% of staff had completed advanced (level two) safeguarding training. The trust's internal target for completion of training was 90%. Records showed 92% of staff across the eye hospital had completed basic (level one) safeguarding training and 90% of staff had completed advanced (level two) safeguarding training. These figures were in line with (or slightly better than) the trust's internal compliance target of 90%.
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was clearly displayed in the areas we inspected.
- Each area we inspected also had safeguarding link nurses in place. There was a safeguarding lead for the surgical services that provided advice and support for staff.
- Safeguarding incidents were reviewed by the departmental managers and also by the trust safeguarding effectiveness committee, which held meetings every three months to review individual incidents and to look for trends.

Mandatory training

- Staff received annual mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and conflict resolution.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.

Surgery

- The overall mandatory training completion rate for staff at the MRI was 83% and 87.7% at the eye hospital. This showed the majority of staff had completed their mandatory training. However, this was below the trust's internal target of 90% compliance.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was daily involvement by ward managers and matrons to address and manage these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Staff used early warning score systems (EWS) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- Staff recorded patient information on an electronic EWS system. This calculated the EWS score and automatically notified the medical team to alert them if there had been any changes to the patient's condition.
- If a patient's health deteriorated, staff were supported with medical input. The trust target was to respond to alerts within one hour on 75% of occasions. Records showed this target was consistently achieved across the surgery services over the past year.
- Patient records showed that staff had escalated concerns correctly, and repeat observations were taken within necessary time frames to support patient safety.
- In total across the two hospitals, we observed five theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The trust-wide clinical audit team carried out an audit during August and September 2015 to monitor adherence to the WHO checklist. The audit of the MRI included review of 30 completed checklist records, observation of two theatre team briefs and two patient checks.

- The audit showed 100% compliance was achieved for 12 out of the 14 indicators in the observational checks. The audit also showed that 100% of the checklist records reviewed were present but only 10% had been fully completed, with information such as patient details and sign in, sign out and time out phases not always documented fully by staff.
- The audit of the MREH included observing three theatre team briefs, eight patient checks and reviewing 13 completed checklist records. The audit showed compliance of 100% was achieved for all 14 indicators in the observational checks. The audit also showed that 100% of checklist records were present but only 8% had been fully completed, with information such as patient details and sign in, sign out and time out phases not always documented fully by staff.
- The WHO checklist audit was scheduled to take place each month and an action plan was in place with improvement actions such as a redesign of the checklist record and additional training for staff to improve compliance.

Nursing staffing

- Nurse staffing levels were reviewed every six months against minimum compliance standards, based on national NHS safe staffing guidelines. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The ward managers and matrons at the MRI told us staffing levels were based on the dependency of patients and was reviewed daily. Patients that required additional support and monitoring were provided with 1:1 care by care support workers that stayed with the patients at all times and could contact a nurse if needed.
- The lead nurse for the division of surgery told us that at the end of September 2015, there were 44.5 whole time equivalent (wte) nursing vacancies and 26.5 wte support worker vacancies in the wards at the MRI. There were also 28 wte nursing vacancies and 13 wte support worker vacancies in the theatres. However, we found the staffing levels in the wards and theatre levels were sufficient to provide safe care and treatment for patients.
- There were plans in place for the MRI to recruit 60 nurses from the European Union and internationally between

Surgery

the time of our inspection and the end of January 2016. This was in addition to the planned recruitment of approximately 150 staff from the trust's domestic recruitment programme.

- The matron and ward manager at MREH told us ward staffing levels were near full establishment. There were two vacancies in the ward areas and these positions had been recruited to with planned start dates during November 2015 and January 2016.
- The nursing staff at MREH were supported by an assistant nursing practitioner (ANP) who assisted in admitting patients to the ward and was trained to carry out venepuncture and cannulation. Two additional ANP's had been appointed and were awaiting start dates.
- There were 2.5 whole time equivalent vacancies for scrub nurses and two anaesthetic nurse vacancies in theatres at the MREH. The scrub nurse vacancies were expected to be filled by January 2016 through the appointment of international nurses as part of the trust's overall nursing recruitment programme. The theatres services had funding approved in September 2015 for four anaesthetic nurses and these posts had been advertised for recruitment.
- The matrons and ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. In the MRI, nursing and care staff that were deemed surplus were routinely transferred to other wards where staffing shortfalls were identified. Staffing levels were also maintained through the use of overtime for existing staff, as well as through the use of NHS professionals' agency staff.
- Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment. The theatres department used approximately 20 regular long term agency staff that had undergone induction training and were familiar with the theatre department's policies and procedures.
- Ward staff told us they felt busy at all times and told us their workload increased when high dependency patients were admitted to the wards. However, they told us they felt they were able to provide safe care to patients.
- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.

- Patients spoke positively about the staff and did not highlight any concerns relating to staffing numbers.

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants and registrars was greater than the England average. The proportion of middle career doctors was below the England average (8% compared with the England average of 11%). The proportion of junior doctors was also below the England average (6% compared with the England average of 12%).
- Staff rotas showed each surgical specialty had sufficient on-site and on-call consultant cover during weekdays. Each specialty area had at least one consultant providing cover over a 24 hour period.
- For example, cover for general surgery was provided by two consultants (a general surgery consultant and a HPB consultant). Each consultant worked on site during normal weekday working hours and was on call outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- At the MRI, there were two rotas in place for ward-based middle grade doctors covering a 24-hour period. One rota covered general surgery, vascular and trauma and orthopaedic specialties (RSO1) and the second rota for ENT, cardiothoracic and urology specialties (RSO2).
- A business case had been submitted to split the RSO1 rota into two separate rotas: one for trauma and orthopaedics and one for general and vascular surgery to improve patient care by reducing cross-cover of specialties and to ensure sufficient cover was available at all times.
- Medical cover on the wards at MREH was provided by at least one junior doctor who was based on the wards.
- Junior and middle grade doctors told us they received good support and could easily access the on-call consultant if needed.
- The clinical head of division for surgery told us there were no consultant vacancies and the group of consultants, middle grade doctors and registrars at the hospital were experienced so they were able to meet patient needs effectively.

Surgery

- The clinical head of division told us three consultants (a transplant consultant, a maxillofacial surgery consultant and an urologist) had recently been recruited and were due to commence employment at the end of November 2015. There was a vacancy for a middle grade urology doctor and there were plans to recruit a doctor from Nigeria to fill this vacancy.
- Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

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

Are surgery services effective?

Good



We rated surgical services as 'Good' for Effective because;

Surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken to improve compliance in audits such as the national hip fracture audit and bowel cancer audit.

The average length of stay for all elective and non-elective surgery patients at the Eye Hospital was shorter (better) than the England average. The readmission rates for non-elective eye surgery patients was also better than the England average. However, the number of elective patients

that were readmitted to the hospital following discharge was worse than the England average. The average length of stay for elective and non-elective urology and general surgery patients and the number of patients that were readmitted to the MRI following discharge was worse than the England average for some specialties. An improvement plan was in place to improve performance and the care and treatment provided to patients.

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

Evidence-based care and treatment

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Ophthalmologists guidelines.
- Clinical audits included monitoring of compliance with National Institute for Health and Care Excellence (NICE) guidance. Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- In 2014/15, the trust participated in 100% of national clinical audits and 100% of national confidential enquiries for which it was eligible to participate in. At the time of our inspection, the division of surgery at the MRI was involved in 32 local and national clinical audits. The clinical audit plan 2015/16 showed the MREH ophthalmic division was currently involved in 52 local and national clinical audits. This included four audits that had been completed, 30 audits that had commenced and 18 audits that had not yet started.
- Findings from clinical audits were reviewed at the monthly clinical effectiveness meetings and any changes to guidance and the impact that it would have on practice was discussed.

Surgery

- Staff used a range of integrated care pathways for surgical procedures such as for macular treatment; glaucoma and cataract surgery and these were based on national guidelines. The hospital was identified as a NICE exemplar (best practice) service for the management of glaucoma.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible via the trust's intranet. We looked at four policies and procedures on the hospital's intranet and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- Staff in the surgical wards and theatres at both hospitals were supported by a team of acute pain specialist nurses.
- The patient records we looked at showed that patients received the required pain relief and 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 patient records included an assessment of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, they were assessed by the medical staff to ensure their safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk. Patients with difficulties eating and drinking were placed on special diets.
- Wards had 'protected mealtimes' in place when all other activities on the wards stopped, if it was safe for them to do so. This meant staff were available to help serve food and assist those patients who needed help.
- Staff also used a red tray system to identify patients who needed support with eating and drinking for example, those living with dementia could be identified and supported during mealtimes.
- Patients told us they were offered a choice of food and drink and did not highlight any concerns about the quality of the food offered.

Patient outcomes

- The national emergency laparotomy audit (NELA) report from May 2014 showed that 19 out of the 28 standards were available at this hospital. This included having a fully staffed emergency theatre available at all times, an emergency surgical unit and a care pathway for the management of patients with sepsis. The NELA audit highlighted a number of standards that were not achieved including arrangements for medical review of elderly patients, the availability of a pathway for enhanced recovery, a policy for deferment of elective activity to prioritise emergencies, and policies that require consultant surgeons and anaesthetists formally hand over in person.
- The findings from the NELA audit had been reviewed and this concluded that the surgical services were compliant with most areas of the NELA audit and no further remedial actions were required. The review highlighted that the service was not able to fully assess morbidity, frailty and cognition in all patients aged over 70 years because the division did not have the resources for a geriatrician to regularly cover the surgical wards. This was addressed by referring patients to a geriatric consultant on an ad-hoc basis where a review was required. The lung cancer audit 2014 (reporting on all of 2013) showed the trust performed in line with or slightly better than the England and Wales average for all three key indicators. This included number of cases discussed at multidisciplinary meetings (97.6% compared with the average of 95.6%), the percentage of patients having a CT scan before bronchoscopy (92% compared with the average of 91.2%) and the percentage of patients receiving surgery in all cases (15.6% compared with the average of 15.1%).
- The national bowel cancer audit of 2014 showed that the trust performed better than the England average for case ascertainment rate, the number of patients that had a CT scan, the number of patients seen by a clinical nurse specialist, the number of cases discussed at multidisciplinary team meetings and the number of patients for whom major surgery was carried out as urgent or emergency.
- The national bowel cancer audit also showed that the trust was slightly worse than the England average for the

Surgery

number of cases discussed at multidisciplinary team meetings (98% compared with England average of 99.1%) and for patient length of stay above five days (73.7% compared with average of 69.1%).

- The bowel cancer audit action plan listed a number of improvement actions in relation to improving the quality of records and for improving the way multidisciplinary meetings were carried out. The lead clinician for colorectal surgery was responsible for implementing the planned actions and progress against agreed actions was monitored at monthly clinical effectiveness committee meetings.
- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was better than the England average. There was also a lower proportion of patients with worsening outcomes than the England average.
- The national hip fracture audit of 2014 showed that this hospital performed similar to or better than the England average for four out of the seven indicators, including the percentage of patients admitted to orthopaedic care within four hours, the number of patients having a bone health assessment, the number of patients developing pressure ulcers and the completion of falls assessments.
- However, the hip fracture report highlighted that only 19.2% of patients had a pre-operative assessment by an orthopaedic geriatrician compared with the England average of 51.6%.
- The hip fracture report also highlighted that the hospital's performance was worse than the England average for the number of patients undergoing surgery on the day of or after the day of admission (68% compared with the England average of 73.8%) and the mean total length of patient stay (28.4 days compared with 19 days).
- The hip fracture audit action plan from November 2015 highlighted that only part-time consultant orthopaedic geriatrician cover (0.45 whole time equivalent) was available at the hospital over five days per week.
- A summary report and action plan was submitted to the divisional clinical effectiveness board during November 2015. This listed a number of remedial actions to improve compliance with the hip fracture audit. For example, service improvement workshops took place during October 2015 to improve compliance with national guidelines and improve the service.
- The action plan also listed key actions to review the capability of the orthopaedic geriatrician and to identify whether additional staff were required to review patients. The action plan highlighted that increasing orthopaedic geriatrician cover at the hospital would also lead to an improvement in the length of stay. This action was planned for completion by November 2016.
- Hospital episode statistics data between January 2014 and December 2014 showed the average length of stay for elective and non-elective urology and general surgery patients was longer than the England average.
- Hospital episode statistics data between December 2013 and November 2014 showed the number of patients that underwent elective urology and general surgery and were readmitted to the MRI following discharge was worse than the England average. Similarly, the number of patients that underwent non-elective trauma and orthopaedics surgery and were readmitted to the hospital following discharge was also worse than the England average.
- The division of surgery had started a specific improvement plan (known as ERAS+) during October and November 2015 to improve patient length of stay along with a project to reduce readmissions to the hospital.
- This involved the implementation of enhanced care pathways for the surgical specialties and improvements to the information given to patients, post-operative multidisciplinary meetings and the introduction of a 'consultant of the week' for some of the surgical specialties so that patients could be reviewed promptly and discharged earlier by 10am. The emergency readmission rate was currently 10.3% with a target to reduce this to below 10% over the next 12 months following the implementation of ERAS+ and the 'consultant of the week'.
- Hospital episode statistics data between December 2013 and November 2014 showed the number of patients that underwent elective surgery that were readmitted to the MREH following discharge was worse than the England average. However, the data showed the number of patients readmitted following non-elective surgery was better than the England average.

Surgery

- Records showed that between July 2014 and July 2015 the rate of emergency readmissions following 28 days of surgery at the MREH was 2.1%. This was better than the overall rate across the whole trust. The nursing and medical staff we spoke with could not attribute the patient readmission rates to any specific factors.
- Hospital episode statistics data between January 2014 and December 2014 showed the average length of stay for all elective and non-elective surgery patients at the MREH was shorter than the England average.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Appraisals were on-going and staff told us they routinely received supervision and annual appraisals. Records up to November 2015 showed the majority of staff across the division of surgery at the MRI had completed their annual appraisals (84%) although the trust target for 90% appraisal completion had not been achieved. Records also showed the majority of staff across at the MREH had completed their annual appraisals (86%).
- Records showed that General Medical Council revalidations for all surgical medical staff had been completed and there were 13 recommendations and two deferral requests made.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the registrar.
- There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays and Sundays.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- Staff used paper based patient records and an electronic patient records system was also in use at the MREH, this allowed staff to access some patient notes electronically. Ward staff told us patients notes usually accompanied the patients but the notes were sometimes delayed from the outpatients' services.
- The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Notice boards detailed information relating to staffing levels and identified patients with specific needs, such as patients at risk of falls. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.

Surgery

- Staff told us that information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the hospital's intranet.
- Patients that required urgent treatment (such as patients with cancer) were admitted for day surgery as part of a rapid access service. However, the patient notes were not always accessible by staff carrying out pre-operative assessments for these patients. Staff told us they encountered this issue approximately two or three times per week and that treatment for these patients could be delayed or operations cancelled. This was because the patient's medical history was not available to allow a proper nursing and anaesthetic assessment to take place.
- An electronic patient records system had recently been introduced across the division of surgery and this was expected to address this issue as the system allowed staff to access patient notes electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
- Patient records showed that verbal or written consent had been obtained from patients and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- If patients lacked the capacity to make an informed decision, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the trust's safeguarding policies.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity to make an informed decision about their treatment. We looked at two patient records where deprivation of liberty safeguards applications had been made; the records for these were in place and had been completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberty safeguards applications.

Are surgery services caring?

Good



We rated surgery services as 'Good' for Caring because;

We spoke with 14 patients and they all spoke positively about their care and the way they were treated by staff. Staff treated patients with dignity and respect. Patients were involved in their care and treatment and staff clearly explained treatment to them in a way they could understand.

Patient feedback from the NHS Friends and Family Test showed most patients were positive about recommending surgery services to friends and family.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the wards and theatre areas.
- Patients' bed curtains were drawn when providing care and treatment and staff spoke with patients in private to maintain confidentiality.
- Patients could also be transferred to side rooms to provide privacy and to respect their dignity. We observed that the privacy and dignity of patients being transferred to the theatre areas was maintained and patients were provided with gowns and blankets.
- We spoke with 14 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: "The nurses are brilliant", "cannot fault the staff, they are excellent" and "could not wish for better care".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between July 2014 and June 2015 showed that the surgical wards consistently scored above (better than) the England average, indicating that most patients were positive about recommending the hospital's surgical wards to friends and family.
- The percentage of patients that completed the survey out of all eligible patients (average response rate) was

Surgery

21.9% at the MRI and 33.2% at the MREH, which was worse than the England average of 36.4%. Ward staff told us they routinely encouraged more patients to complete the test when they were discharged from the hospital.

- A review of data from the CQC's adult inpatient survey 2014 showed that the trust was about the same compared with other trusts for all 10 sections, based on 308 responses received from patients.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took individual patient preferences into account.
- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand. Staff were respectful and sought permission from patients before they were transferred to the theatres.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. We saw that medical ward rounds occurred on a daily basis and included input from the nursing staff and other health professionals such as physiotherapists if needed.

Emotional support

- Staff understood the importance of providing patients with emotional support. Patients told us the staff were calm, reassuring and supportive and this helped them to relax prior to undergoing surgery.
- The matron at MREH told us a nurse accompanied patients and held their hand throughout their surgical procedure to provide additional emotional support.
- Staff on each ward carried out a specific walk round on each shift to ask each patient if they experienced any pain or had any fears or worries. This gave patients the opportunity to discuss any concerns or anxieties.

- Patients told us they were supported with their emotional needs. Information was available to patients and their relatives about chaplaincy services and bereavement or counselling services.
- Staff could also access psychological support for the families of patients who were seriously ill.

Are surgery services responsive?

Good



We rated surgery services as 'Good' for Responsive because;

The surgical services achieved the 18 week referral to treatment standards across all specialties. Services were planned to meet the needs of local people. For example, there was an emergency general surgery and trauma theatre that was staffed 24-hours, seven days per week so that patients requiring emergency surgery during out of hours and weekends could be operated on promptly. NHS England data showed the rate of cancelled elective operations across the trust was higher (worse) than the England average since July 2014. However, the number of operations cancelled at the MREH was within expected levels.

Data showed the number of patients at the MRI whose operations were cancelled and were not treated within the 28 days had improved. The division of surgery transformation plan included actions to improve theatre efficiency and reduce cancelled operations. The MREH did not have issues with capacity and the rate of operations cancelled at the hospital was low and within expected levels.

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

Service planning and delivery to meet the needs of local people

- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the MRI, such as neuro-surgery, breast surgery and plastic surgery.

Surgery

- There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven days per week so that patients requiring emergency surgery during out of hours and weekends could be operated on promptly.
- The majority of elective orthopaedic surgery services were provided from Trafford General Hospital. Patients requiring elective orthopaedic surgery that were assessed as high risk (e.g. with complex health needs) were treated at Manchester Royal Infirmary along with all emergency trauma and orthopaedic procedures.
- The MREH provided day case cataract surgery from the Withington Cataract Centre.
- There was a surgical admissions receiving unit on each of the male and female wards in the emergency surgical trauma unit (ESTU), each had a waiting area with four trolley spaces and three chairs. The ESTU admitted emergency patients from a range of specialties including head and neck, urology and all emergency fractured neck of femur (hip fracture) patients. Patients were assessed and then transferred to other specialty surgical wards.
- The elective treatment centre (ETC) consisted of two separate wards; a day case ward and a short stay ward. The day case ward had 39 trolley spaces that also included 11 to 13 trolley spaces that were used as a surgical admissions lounge. The ETC short stay ward had 27 beds with 15 beds allocated for day cases and 12 beds for patients that underwent elective surgery and required a hospital stay up to three nights.
- The vascular surgery unit (ward 7) at the hospital had capacity for 26 patients. The trust planned to transfer the vascular services from another local trust during 2016 with a planned increase of nine beds on ward 7.
- Ophthalmology surgical services were provided for both adults and children. The inpatient wards (ward 54 and 55) provided overnight accommodation for adults only. Children were admitted as day cases or transferred directly to the theatres from other parts of the trust, such as the children's hospital.
- The day case unit at the MREH included a pre-assessment for up to eight patients. Patients were given staggered morning and afternoon appointment times to avoid long waiting times. The unit included six examination rooms, three interview rooms and a number of specialist treatment rooms. The macular treatment centre was also located in the day case unit. This had two injection rooms, clinical imaging facilities

and seven examination rooms. Staff on the unit could provide patients with an electronic paging device to allow them to leave the waiting area so they could be contacted when their appointment was due.

- Patients undergoing elective surgery at MREH were also admitted to the hospital via a surgical admissions lounge (SAL), which admitted patients for morning and afternoon sessions at 7:30am and 11:30am Monday to Friday. The SAL had a waiting area that could accommodate up to eight patients with two four-bed bays to allow appropriate male and female segregation.
- The MREH also offered laser vision correction surgery for private patients. The private eye ward (ward 54) had four en-suite rooms and a treatment room that was used for private patients. Laser surgery was normally carried out once a week by a specialist consultant.
- The MREH had five operating theatres, including a paediatric (children's) theatre. The operating theatres at the hospital were also used by other specialties, such as for oral and dental surgical procedures.
- The areas we inspected were compliant with same-sex accommodation guidelines.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patients admitted via accident and emergency were directed to the ESTU but there were no direct GP admissions. Patients admitted by GP referral were admitted via the accident and emergency department.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients

Surgery

were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.

- At the MREH, the ward clerk told us they sometimes experienced delays in discharging patients from the ward during the evenings due to issues with transport services (provided by an external organisation). A discharge project had recently started to improve patient discharge processes. This involved carrying out discharge planning at an early stage and carrying out checks such as transport booking and availability to reduce delays to patient discharges.
- NHS England data showed the overall trust-wide bed occupancy rate between October 2013 and March 2015 ranged between 91% and 93.8%. The high level of bed occupancy was reflected in the surgical wards we visited as we found that most available beds were occupied. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- Surgical doctors at MRI told us they were issued with a daily list of surgical patients across the hospital's wards and they made sure surgical outlier patients were seen daily. Ward staff across the surgical wards confirmed patients were seen by specialty doctors on a daily basis.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. However, some beds at MREH were also used to accommodate surgical and medical patients (outliers) from other parts of the trust (such as the MRI). For example, there were two medical outliers and one surgical outlier on one day during the inspection and two surgical outliers on the ward during our unannounced inspection. Ward staff confirmed that outlying patients were routinely assessed by doctors from the relevant medicine and surgical specialties.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation. There was a designated area in recovery for critically ill patients that required stabilising prior to transfer to the intensive care / high dependency unit.
- An extended recovery service was available to allow up to two patients to be kept overnight in the recovery area. Extended recovery patients received overnight care from at least two nurses and there were suitable facilities to allow the patients to remain in the recovery area overnight.
- NHS England data showed national targets for 18 week referral to treatment standards for admitted patients (90%) were being met for all specialties at the end of July 2015.
- NHS England data showed the rate of cancelled elective operations across the trust was higher (worse) than the England average since July 2014. Trust data up to September 2015 showed the rate of operations cancelled in the division of surgery was 3.4% which was higher than the trust target of 0.8%. However, the number of operations cancelled at the MREH was within expected levels.
- Trust divisional data between April 2014 and October 2015 for operations cancelled on the day of surgery showed there were 510 operations cancelled on the day of surgery for clinical reasons and 514 operations cancelled on the day of surgery for non-clinical reasons.
- The main reasons for non-clinical cancellations were due to ward beds unavailable (23%), high dependency (HDU) beds unavailable (24%) and theatre session over runs (24%).
- NHS England data showed that between October 2014 and June 2015 the trust performed worse than the England average for the number of patients whose operations were cancelled and were not treated within 28 days. A total of 99 patients were not treated within 28 days during this period.
- However, data from October to December 2015 showed an improving picture 345 operation cancelled of which 11 were not treated within 28 days. The number of patients whose operations were cancelled and were not treated within 28 days at the MREH was better than the England average.
- The divisional director and the divisional head of nursing told us the main reason for not treating patients within 28 days of a cancelled operation was that patients were given appointments on the day of their cancellation. However, their operation would be cancelled again if patients underwent a complex procedure (e.g. maxillofacial surgery) and there was a lack of high dependency beds available.
- During the inspection, we found the ETC short stay ward was used to accommodate emergency surgical patients from other surgical wards due to bed constraints. This reduced the number of beds available for elective patients and meant that some elective procedures were cancelled either before or on the day of surgery.

Surgery

- The head of nursing for the division of surgery told us only patients assessed as low risk were transferred to the ETC short stay ward. During our unannounced inspection the short stay ward had 27 overnight short stay patients, including 12 elective surgery patients and 14 emergency patients from other surgical wards. Staffing levels on the ETC at the time of our inspection were adequate to meet the needs of these patients.
- Records showed that between May 2015 and July 2015 the theatre utilisation (efficiency) rates at MRI ranged between 12.1% and 108.9% with an overall average of 75%. At MREH the utilisation rates ranged between 84% and 113% during this period. Records between December 2014 and November 2015 showed 40-60% of theatre sessions at MREH started within 15 minutes and 60-70% of theatre lists finished on time.
- The MREH's theatre improvement project listed a number of improvement actions to improve patient turnaround times and to consistently achieve theatre utilisation rates of 95%. The improvement plan included the introduction of the surgical admissions lounge and improvements to theatre scheduling processes.
- At the MRI, the divisional transformation plan included a number of improvement actions to improve patient flow over the next 12 months such as: improving bed capacity by reducing patient length of stay and improvements to discharge processes, improving theatre utilisation from 70% to 90% and increasing the number of operations where patients are sent for on time from 33% to 50%. Improvement projects listed in the transformation plan had designated project leads and the progress and implementation of actions was reviewed at divisional management board meetings every three months.

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 received mandatory training in dementia care. The areas we inspected also had dementia link nurses in place. Staff could also contact the trust-wide safeguarding team for advice and support around caring for patients living with dementia or a learning disability.
- Staff used a 'remember me' and 'learning disabilities passport' document for patients who had a learning disability or were living with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- There was a complex discharge team in place that included multidisciplinary professionals including social workers and physiotherapists. The complex discharge team provided support for patients with complex social or healthcare needs that required additional support or equipment following their discharge.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the care and treatment of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The theatre recovery areas at MREH had two designated paediatric recovery bays so children and adults could be appropriately segregated.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.
- The ward and theatre matrons were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a complaints coordinator in the division of surgery, who notified individual matrons when complaints were overdue.
- Staff understood the process for receiving and handling complaints. Staff told us that information about complaints was discussed at routine staff meetings to aid future learning.
- Records showed that between August 2014 and July 2015 there were 239 complaints relating to the surgical services at the MRI. The most frequent reasons for complaints were due to communication failures and delayed procedures. There were 17 complaints relating to the ophthalmology surgical services at the MREH within the same period.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 25 working days for routine formal complaints.

Surgery

- Records up to September 2015 showed that only 17% of complaints relating to surgery at MRI and 69.6% of complaints relating to surgery at MREH had been resolved within 25 days (against a target of 80%). The records also showed that 47.6% of the complaints relating to MRI and 59.4% of complaints relating to MREH remained unresolved compared to a target of 20%. This meant that complaints about the surgical services were not always responded to in a timely manner.

Are surgery services well-led?

Good



We have rated surgery services as 'Good' for Well-led because;

The trust vision and values had been cascaded across the surgical wards and departments and staff had a clear understanding of what these involved. The wards and theatres had clear and clearly visible leadership with clinical, nursing and business leads.

The majority of staff were positive about the culture and support available. Monthly clinical effectiveness meetings reviewed incidents, key risks and monitoring of performance. There was routine public and staff engagement and actions were taken to improve the services.

Vision and strategy for this service

- The trust vision was "to be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for our diverse population".
- This was supported by a set of values and behaviours based on "communication", "leadership", "celebrating achievement and accountability", "to deliver the best patient care" and "to listen and respond".
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.
- The division of surgery transformation plan outlined the strategy for the service and included key performance

objectives in relation to reducing the length of stay, improving theatre efficiency and improving patient experience. A presentation had been cascaded to all staff to make them aware of the plan.

- The Manchester Royal Eye Hospital (ophthalmic) division draft strategy, August 2015 outlined the vision and strategy for the service and listed key performance objectives in relation to clinical quality and an overall strategy to provide integrated, cross geographical services that are closer to people's homes.

Governance, risk management and quality measurement

- There were monthly clinical effectiveness meetings and a number of weekly and monthly staff meetings that took place across the division of surgery. There was a set agenda for these meetings with standing items including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented on a divisional risk register that included departmental risks. Staff were aware of how to record and escalate key risks on the risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Clinical effectiveness committee meeting minutes showed the risk register was reviewed and updated on a monthly basis.
- The key risks to the services at MREH were identified as the management of medical records and the occurrence of never events. There were actions in place to address these risks, such as the use of the electronic patient records and improvements to surgical safety checklists and training for theatres staff to reduce the risk of never events taking place.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored via the clinical effectiveness committee and cascaded to ward and theatre managers through performance dashboards.

Leadership of service

Surgery

- The surgical services provided at the MRI were part of the division of surgery. The divisional director was the overall lead for surgical services at the hospital. The divisional director was supported by the clinical head of division, the divisional head of nursing and two associate directors.
- The surgical wards were led by ward managers that reported to the matrons. The matron for theatres oversaw the main and elective theatre areas.
- The ophthalmology surgical services provided at the MREH were incorporated into the Manchester Royal Eye Hospital (ophthalmic) division. The clinical head of division was the overall lead for ophthalmology surgical services at the hospital. The clinical head of division was supported by the divisional director and the divisional head of nursing.
- The surgical services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical director, matron and directorate manager.
- The theatres and ward based staff told us they understood the reporting structures clearly and that they received good support from their line managers.

Culture within the service

- Staff were proud, highly motivated and spoke positively about the care they delivered.
- The majority of nursing and medical staff told us there was a friendly and open culture and did not highlight any concerns about the culture within the service. However, we received some less positive feedback from some ward staff at the MRI, who told us the level of vacancies and use of agency staff increased their workload and that this affected their morale.
- We also received feedback that highlighted a culture of bullying and discrimination of medical staff by colleagues and peers within the surgical team at MRI. The divisional director and the clinical head of division told us they were aware of instances where bullying had been reported and felt these were isolated issues that were being addressed through the trust's human resources (HR) processes.
- Records up to September 2015 showed the staff sickness rate across the surgery services at MRI was 4.5%. This was slightly better than the overall trust average (4.8%) but was worse than the trust sickness absence target of 3.6%. Similarly the staff sickness rate

across surgery services at MREH was 4.2%. These rates were slightly better than the overall trust average (4.8%) but worse than the trust's internal sickness absence target of 3.6%.

- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained with overtime for existing staff and with agency staff.
- Records up to September 2015 showed the staff turnover rate was 0.2% at MREH and 0.6% at MRI. This was better than the trust target of 1.1%.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.
- There had been ad hoc patient engagement through patient focus groups, such as the pelvic floor focus group and the upper gastro-intestinal focus group.
- Patient feedback was gained through patient surveys carried out as part of the improving quality programme. Staff across each department carried out daily patient surveys covering 12 key areas including patient safety, cleanliness, communication, privacy and dignity, pain management and good nutrition. The ward managers also carried out a monthly visit to speak with patients about these key areas.
- Patient feedback was sought from 24 patients at MREH during November 2015 following the implementation of the surgical admissions lounge. The feedback was mostly positive and was used to identify areas of improvement.
- The survey results were collated each month and these were displayed in each area we inspected. The survey results between September 2014 and September 2015 showed the surgical services consistently achieved the minimum standard of 85% for all the survey questions except for 'providing good nutrition' and 'ensuring pain is managed'.
- There were improvement plans in place to improve compliance in these two areas. This included improvements in the quality and presentation of meals and greater involvement by nursing staff during meal times.

Staff engagement







Surgery

- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected.
- The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The trust had eight positive findings within the NHS staff survey of 2014 and the remaining 22 questions were within expected levels when compared to other trusts.
- The general medical council identified concerns in August 2015 relating to the management of trainees and their training experience at the MREH. The concerns raised included current trainees reporting that they were not receiving adequate experience to complete their required surgical experience objectives and trainees were experiencing stress due to current workload.
- Remedial actions taken to address these concerns included the allocation of additional staff to the emergency eye centre and additional trainee engagement sessions so that additional support and guidance could be provided.
- The ophthalmology surgical wards had also completed the accreditation scheme and had achieved a 'gold' rating, which meant the ophthalmology surgical wards were meeting / exceeding the trust's ward accreditation standards.
- Services at MREH worked collaboratively with the University of Manchester providing the majority of clinical placements for their undergraduate students. Staff at the hospital participated in a range of clinical trials and research programmes, such as research for retinal disease and inherited disorders. The hospital was identified as a NICE exemplar (best practice) service for the management of glaucoma.
- A 'hot clinic' service had been in place since April 2014 to provide treatments such as ultrasound scans without the need for a patient to be admitted to the MRI. The clinic operated two sessions per week between 10am and 2pm during weekdays and patients were seen by a doctor supported by a support worker.
- The hot clinic area had a waiting area with seven chairs and a treatment room with mobile scanning equipment. Records showed 1344 patients were treated at the clinic between April 2014 and October 2015 and approximately 2.2 inpatient beds per day were saved as a result of these patients being treated without admission to the inpatient wards.
- The divisional director, clinical head of division and head of nursing for the division of surgery were confident about the future sustainability of the surgical services at the MRI. They told us the key risks to the services were around nurse staffing levels and patient access and flow and felt the divisional transformation plan and ongoing recruitment would address these issues.

Innovation, improvement and sustainability

- The surgical wards at MRI and elective treatment centre had completed the trust ward accreditation scheme based on a number of nursing standards with an achievement rating of bronze, silver or gold. One ward achieved a 'bronze' award and all other wards achieved a 'silver' award across the division of surgery, which meant most surgical wards were meeting the trust's ward accreditation standards.

Critical care

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

Information about the service

Critical care at Manchester Royal Infirmary is delivered in three distinct clinical areas. There is a general adult critical care unit that is divided into an intensive care unit (commissioned to provide care and treatment to 17 level three patients) and a high dependency unit (commissioned to provide 18 level two beds). In addition, there is a cardiac intensive care unit that provides 12 patients with level 2 and/or 3 care and treatment. The adult critical care unit and the cardiac intensive unit are managed and staffed separately whilst both providing critical care to their respective patient groups.

For the purposes of management and governance, the general adult critical care service (intensive care – level 3 and high dependency – level 2) sat in the Critical Care Directorate within the Clinical and Scientific Services Division. The cardiac intensive care unit was governed within the auspices of the Manchester Heart Centre, which sat in the Specialist Medicine Division

Summary of findings

We rated critical care services as ‘Good’ overall.

There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. There was not always a supernumerary shift coordinator on shift on the cardiac intensive care unit at night. However, we raised this with the trust and they responded immediately to this shortfall, implementing an action plan which ensured that staffing numbers on night duty met with the intensive care society standard. We found a culture where incident reporting and learning was embedded and used by staff.

The clinical areas benefited from recent refurbishment and met with the latest health building note guidance. The units also benefited from excellent levels of equipment and maintenance with dedicated critical care technologists supporting the service. There was strong clinical and managerial leadership at unit and divisional level. The unit had a vision and business plan for the next five years. There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

The units continued to collect and submit data for the intensive care national audit and research centre (ICNARC) and the central cardiac audit database (CCAD) for validation, so they were able to benchmark

Critical care

performance against comparable units. These data showed that apart from delayed discharges, patient outcomes were within the expected ranges when compared with similar critical care units nationally. In terms of unit acquired infections the data indicated much better performance than comparable units. We saw patients, their relatives and friends being treated with care, compassion, dignity and respect.

Are critical care services safe?

Good



We have rated critical care services as 'Good' for Safe because;

There were systems in place for reporting and learning from incidents. There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients though there had been a reliance on agency nursing staff who had on occasions comprised more than 20% of the nursing workforce. A recruitment strategy was in place to try and resolve this position.

The facilities and environment generally met with the latest health building note guidance. Staff complied with infection control practices resulting in low infection rates. The critical care services collected and submitted performance data nationally to enable benchmarking against comparable units. In terms of unit acquired infection rates the general adult level 3 and level 2 facilities performed better than comparable units.

Incidents

- The hospital had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff knew about the incident reporting system and were able to give examples of when they had used it.
- For the purpose of incident reporting, both the general adult and cardiac critical care incidents were aggregated into one report. The report for the period August 2014 to August 2015 contained 832 reported incidents across the critical care services. This included incidents for the four bedded 'high care' unit at Trafford General Hospital, which was acquired by Central Manchester University Hospitals Foundation Trust two years ago. Whilst this unit no longer routinely cared for patients at level 2 or level 3, it was still staffed by critical care nurses rotating from the Manchester Royal Infirmary general adult unit. Any incidents that were reported from the 'high care' unit were also aggregated into the wider critical care incident report. In addition, the incident report included figures from the acute cardiac centre (ACC) at Manchester Royal Infirmary.

Critical care

- The report showed the breakdown of incidents reported per unit were as follows: General adult ICU = 374, general adult HDU = 251, Cardiac ICU = 120, ACC = 71 and Trafford = 16. In terms of their severity 203 of these reported incidents were judged as being near misses where there was no harm to the patient. This reflects a culture where reporting is encouraged whether there is patient harm or not.
- In terms of actual harm, during the period covered by the report there were seven incidents that had resulted in moderate harm to patients. Five of these incident reports related to hospital acquired pressure ulcers, one for a methicillin resistant staphylococcus aureus (MRSA) bacteraemia and one related to a medical device user error. These incidents had all been investigated appropriately.
- Incidents, their related investigations and lessons learned were discussed at both directorate and unit level. Staff were able to give us examples of changes to practice and lessons learned as a consequence of reported incidents. For example, one of the main themes for reported incidents related to prescription and medication administration errors. In one specific case the use of abbreviations had resulted in a nurse raising a query regarding the dose and route of administration of insulin. This had resulted in a raised awareness of the risks associated with medicines prescribing and administration. All staff were encouraged to challenge poorly written prescriptions.
- Incidents were also shared at daily core and safety huddles.
- A thorough and robust approach was undertaken to reviews of patient mortality and morbidity. Mortality and morbidity meetings were held monthly and all mortalities were discussed. The minutes of the meetings included action points and highlighted learning opportunities.
- Duty of candour was covered in the trust wide policy covering the reporting of incidents. Training had commenced in August 2015 as part of patient safety training and in October 2015 as an additional standalone course. 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.
- 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 submitted from the unit and reported at divisional level via a clinical safety dashboard.
- Since 2013, there had been a reduction in the prevalence of pressure sores. The units reported a reduction of 60% in general intensive care and 40% in the high dependency area. The majority of pressure ulcers were low grade or unavoidable.
- The recently introduced re-positioning chart had improved documentation. Twenty sets of patient notes were audited monthly to review pressure area assessment documentation with the results presented monthly at a harm free care lunchtime training session.

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.
- The critical care areas provided isolation cubicles, which met with the most recent building notes guidance.
- Personal protective equipment was available for staff and we saw it being used appropriately. There were sufficient hand washing facilities and antiseptic gels available.
- Our observations showed clinical staff washed their hands and applied antiseptic gels as appropriate between patients and their bad spaces. Weekly hand hygiene audits were undertaken for all critical care areas. The results showed high levels of compliance, (95-100%).
- Data was collected on central venous catheter blood stream infections (CVCBSI) and displayed at divisional level on the clinical safety dashboard. The most recent results for quarter one of 2015 showed a CVCBSI rate of 0.5 per 1000 CVC days. This represents a low risk and indeed indicated a lower risk of infection (1.4 per 1000 CVC days) than was achieved during the original Michigan study in the USA.
- The intensive care national audit and research centre (ICNARC) data supplied by the trust, for the period October to December 2014, showed that the unit was performing better than similar units for the number of

Safety thermometer

Critical care

patients who acquired MRSA, clostridium difficile and infections in blood. In fact, the ICNARC data showed that there had been no patients with unit acquired infections in blood. We asked the trust for more recent validated data but none was provided. ICNARC do make public their collected and validated data in an annual report, the report for 2015 will be due early 2016.

- Additional evidence was presented to show that in the general adult intensive care unit it had been 131 days since a patient had acquired a Clostridium difficile infection and 165 days since a patient had acquired a MRSA blood stream infection. For the high dependency unit the figures were 547 days since a patient had acquired a Clostridium difficile infection and 1257 days since a patient had acquired a MRSA blood stream infection.
- An audit of compliance with specific intensive care bundles, undertaken in July 2014, reported the following results: ventilator care bundle – 98.4%, hand hygiene – 98.6% and central line bundle – 94%. As a consequence specific actions were instigated to improve the levels of compliance. For example, measures to increase awareness about various intensive care bundles and effective use of antibiotics. These included organising study days and practical exercises. A re-audit was due in late 2015.

Environment and equipment

- The critical care services were refurbished and completed in 2014. As part of this new refurbishment the facility was designed alongside all relevant regulations, including Health Building Note (HBN) 04-02: Critical care units. Thus, due to the recent refurbishment, the HBN had been achieved as far as reasonably practicable. HBNS give “best practice” guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.
- The hospital undertook equipment and estates maintenance through both the direct estate departments and an outsourced provider. Maintenance was generally undertaken using two defined methodologies: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, annually) to meet statutory requirements, legislation,

manufacturer’s guidance and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure.

- The medical engineering and maintenance department undertook all the servicing and maintenance of equipment under a service level agreement with the division. Detailed records were kept of all equipment alongside a service and maintenance database. In August 2015, critical care was reported as having 2203 items of equipment requiring maintenance with 21% having yet to be serviced. Records showed the higher risk items of equipment such as ventilators and monitors had been serviced.
- Critical care benefited from a dedicated team of technicians who supported the units with not just maintenance and servicing but also training.
- We saw resuscitation equipment was available, including defibrillators and difficult airway management trolleys. Records indicated that these were all checked daily.
- The critical care risk register identified that the monitoring equipment in the high dependency unit would come to the end of its reliable life in two years’ time. A capital bid was being developed for 2017 to enable replacement of monitoring equipment.

Medicines

- The general adult intensive care, high dependency and cardiac intensive care units had dedicated senior pharmacy input but the allocated whole time equivalents (WTE) fell below the intensive care society standards. There should be 0.1 WTE for every level 3 bed and 0.1 WTE for every two level 2 beds.
- The pharmacist attended the daily ward round and covered the units Monday to Friday. However, there was no routine ITU pharmacy cover at the weekend.
- Out of hours pharmacy cover was provided from the pool of hospital pharmacists who may not always have critical care experience.
- Medicines were stored safely and in a locked room. The controlled drugs were held securely. Records indicated they were checked and administered in accordance with the trust policy.
- The medicines storage room and drug fridge temperatures were monitored and recorded daily.

Records

Critical care

- The paper records comprised of a range of clinical records, assessments and plans. These included for example, nutritional risk, falls assessments, physiotherapy treatment plans and skin care bundles. All entries were completed, signed and dated although the legibility of handwritten notes varied.
- Although entries in records were usually signed and dated, the author's name was not always printed alongside the signature. Some entries were also missing the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located close to the bedside. The charts we looked at were comprehensively and accurately completed and brought together all the patient's physiological monitoring, blood results, care planning and management in one place.
- There were plans to introduce an electronic clinical information system from February 2016 and this would include electronic prescribing. Electronic prescribing has been shown to have an impact on patient safety by reducing medication and transcription errors. Staff training on the new system was due to commence in December 2015.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what constituted abuse and neglect.
- The October 2015 edition of the critical care newsletter included a section on safeguarding. The article stated that 'safeguarding our patients is one of the fundamental principles of care'. There had been recent amendments to nursing safeguarding assessments to help ensure that patients who require referral for a deprivation of liberty safeguard consideration are identified as early as possible.
- Safeguarding training was part of the trust mandatory training programme. Records showed that for the general adult critical care units (ICU and HDU) 77% of all staff groups, except medical and allied health professional staff, had completed safeguarding level 1 training, with 75% also having completed level 2 training. For the cardiac critical care units the figures were 86% for level 1 and 77% for level 2 safeguarding training.

- Allied health professionals and medical staff safeguarding training was reported separately as they worked across divisions. 92% of allied health professionals had completed level 1 training and 94% had completed level 2. For medical staff, 74% had completed level 1 and 63% had completed level 2. All the above results were measured against a trust wide target of 90% completion.

Mandatory training

- All staff received mandatory training on a range of topics including infection control, safeguarding, moving and handling and conflict resolution. Mandatory training records were kept by the respective critical care practice education teams.
- Whenever workload allowed, staff were given time to complete e-learning modules. Again depending upon workload pressures, the education team did support unit staff by working alongside them to allow time for completion of mandatory training.
- The clinical mandatory training compliance figure was reported as being 88% and the corporate mandatory training figure as 90%.

Assessing and responding to patient risk

- A range of acute care initiatives had been introduced to assist with the early detection, recognition and timely response to the acutely ill patient and those at risk of deterioration. These included, implementation of an early warning score (EWS) and associated acute care guidance and policies. For example, oxygen guidance, early warning score policy, fluid balance and sepsis policies. EWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically.
- The outreach follow up team were involved in delivering the acute illness management course (AIM) and an acute care study day. These were both considered as part of nurses' mandatory training and helped to promote confidence and competency for ward nurses in caring for acutely ill patients.
- The critical care outreach follow up team worked with the wider multidisciplinary team to ensure that all critical care patients were managed in accordance with NICE guidance 83 (Rehabilitation after critical illness).
- The wider hospital used a patient tracking system. (This was not being used in critical care). The system allowed automatic alert and escalation of deteriorating patients

Critical care

linked to the early warning score system (EWS). This ensured the most appropriate clinicians were informed when a patient became acutely unwell and so ensured a timely response to their deteriorating health. Clinical observations were recorded at the bedside onto a tablet. The software calculated the EWS and where appropriate cascaded an alert to medical and nursing staff. The patient tracking interface allowed clinicians to see where the sickest patients were in the hospital and to remotely view their observations. The alert only stopped when an appropriate level of response and/or reduction in the EWS occurred.

- Audit results showed that the patient track system had eliminated all EWS summation errors and significantly improved the timeliness and completion of observations.
- The resuscitation team, using the patient tracking system, evaluated and discussed all cardiac arrest cases weekly. The discussions involved consultants and ward staff as well as the resuscitation team. Since the introduction of the patient tracking system, the number of cardiac arrests had fallen from six per week to one per week.

Nursing staffing

- The Intensive Care Society patient acuity measure was used to determine the number of staff required on duty.
- At the time of the inspection, there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- The Intensive Care Society standard for nurse staffing states there should be a band 6 or 7 supernumerary clinical coordinator on duty 24 hours a day, seven days a week. At the time of inspection this was not always happening on the cardiac intensive care unit as there was not a supernumerary clinical coordinator on duty during the night shift. We were told of occasions when this supernumerary provision was met but a staff member may then be moved during the night to assist other areas within the hospital. We raised this matter with the directorate senior staff at the time of inspection. They responded promptly by immediately implementing an action plan which gave the cardiac intensive care unit their supernumerary clinical coordinator at night. The action plan included an

instruction that this person was not to be moved to the wards. However, if this did happen then it would be reported as a serious incident to the divisional nurse lead.

- It was recognised and recorded on the critical care risk register that the on-going number of registered nurse vacancies throughout the critical care units was leading to reliance of agency nurses. On some occasions this had meant that more than 20% of the nurses on some shifts were agency nurses. A number of actions were being implemented to try and resolve the issue. These included international recruitment; a number of registered nurses from India were due to start in October 2015 although there had been some delays in terms of securing work permits.
- All new agency staff had an induction on starting their first shift. Audits of the inductions were undertaken by the critical care matrons. Agency staff were not allowed to give intra venous medications unless they had successfully completed the trust IV update training. We spoke with agency nurses during the visit who felt supported and had access to training opportunities.

Medical staffing

- There was a named clinical director, 23 consultants and 24 trainee medical staff for the critical care services. All consultants were Fellows of the Faculty of Intensive Care Medicine (ICM) with direct daytime critical care clinical activity present in their job plans.
- During the week there were four consultants on duty from 8am to 6pm to cover the level 3 and level 2 beds. One of the consultants also undertook ward medical outreach in response to the patient track and EWS system. At the weekend there were three daytime consultants on duty.
- Consultant to patient ratio was normally no more than the 1:8 which was in accordance with Intensive Care Society standards.
- Out of hours the on-call consultant took responsibility from 7pm, with a handover taking place between 6pm and 7pm. The on-call consultant was resident until 11pm and then available to attend if needed within 30 minutes until 8am. They were supported by a minimum of four resident intensive care medicine trainees/fellows who also provided support to the medical outreach service.

Critical care

- The consultant on-call for cardiac critical care also had to cover for cardiac theatres. On such occasions, the cardiac unit was able to call upon the doctors in the adjoining general intensive care unit if required.
- We attended a medical handover that was structured and used a standard handover sheet, that was destroyed afterwards in accordance with data protection. The handover was undisturbed with no distractions.
- Trainee doctors were well supported and as the units at Manchester Royal Infirmary were recognised for higher ICM training, they had advanced trainees and senior clinical fellows. There was a strong ethos of training and education at all levels.
- Locum use was kept to a minimum (0.1%). When locums were used they were required to undertake a full induction which required them to use the patient track system.

Major incident awareness and training

- Working with national legislation and guidance such as the Civil Contingencies Act (2004) and the NHS Emergency Planning Guidance (2005), the critical care services had detailed plans for responding to the increased demands that a major incident would make on services, while continuing to provide care for existing patients.
- We did not see any evidence to demonstrate that the major incident plan had been practiced or tested.

Are critical care services effective?

Good



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

Care was delivered in line with evidence-based, best practice guidance. The adult critical care unit continued to submit data to the intensive care national audit and research centre (ICNARC) for validation. This data showed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally. The exception being for delayed discharges where the unit's performance was slightly worse than the England average.

The majority of cardiac units in the UK do not submit data to ICNARC as their workload is not really comparable with general intensive care practice. As a result the cardiac intensive care unit collected and submitted data on all cardiac surgery patients to the central cardiac audit database (CCAD). This provided a comparative measure of cardiac intensive care practice and showed that the cardiac intensive care unit compared favourably with similar units nationally.

All patients in critical care were assessed in respect of their pain management. Ward rounds took place each day that involved medical, nursing, pharmacy and other allied health professionals as required. Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. A critical care outreach service was provided; a documented discharge pathway was in place which included referral of all discharged critical care patients to the outreach team so they could assess and monitor their progress and recovery. The critical care service was fully compliant with best practice guidance NICE 83 (Rehabilitation after critical illness).

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. This included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The general adult intensive care and high dependency units demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The cardiac intensive care unit demonstrated continuous patient data contributions to the central cardiac audit database (CCAD). This meant that the care delivered and mortality outcomes were benchmarked against similar cardiac intensive care units nationally.
- The critical care units were also subject to an annual peer review by the Greater Manchester Critical Care Network (GMCCN). The purpose of the reviews was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.

Critical care

- Following the most recent GMCCN review in June 2015, the general adult critical care service fully met the majority of the specification requirements. The GMCCN had no immediate or serious concerns. The only issues raised by the review were the absence of 'formal' multi-disciplinary ward rounds, the number of agency staff being used at the time, the level of dedicated pharmacy cover and the numbers of delayed discharges.
- The cardiac intensive care unit was also reviewed by the GMCCN in May 2015 and similarly there were no immediate or serious concerns. The issues raised following the review were formalisation of an admission, transfer and discharge policy, provision of a supernumerary shift leader 24/7, the level of dedicated pharmacy cover, shortfalls in the microbiology service specification, the numbers delayed discharges to the ward and access to follow up clinics for patients with long and complex stays.
- 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.
- All patients were screened on admission and then on an on-going basis for signs of delirium. The assessment and documentation of mental capacity had been the specific critical care patient safety focus for October 2015. This work linked in with early identification of patients with delirium. Patient experience was also being used to raise awareness amongst staff of the sign and symptoms of delirium with former patients involved in staff training.
- The critical care service was the only one fully compliant with NICE guidance 83 (Rehabilitation after critical illness) in the GMCCN. Compliance with this standard required a patient centred approach to treatment and care that was culturally appropriate and accessible to patients with additional needs such as physical, sensory or learning disabilities.
- The critical care units displayed their respective 'quality dashboards' outside the entrance to the units. These reported information gained from the monthly quality care rounds and patient feedback. The critical care units had currently achieved a silver status in the ward accreditation process.
- All patients in critical care were assessed in respect of their pain managements as part of their individual care plan. This included observing for the signs and symptoms of pain. Staff utilised a paper based pain scoring tool.
- On the cardiac intensive care unit there was a protocol for the administration of analgesia prior to the removal of drains after cardiac surgery. This had been introduced following an initial audit. The audit had revealed that only 47% of patients received paracetamol and an opiate prior to drain removal whilst 59% of patients experienced moderate to severe pain on drain removal. Staff were subsequently trained in the administration of Entonox (50% oxygen and 50% nitrous oxide) and this was then used in conjunction with paracetamol and an opiate on drain removal. A re-audit showed an improvement in pain management with 81% of patients having a pain score of less than five compared to 50% previously; 65% had pain scores less than three, five minutes after drain removal compared to 50% previously.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.
- Nutritional risk scores were updated and recorded appropriately in the patients' notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- On the cardiac intensive care unit, the patient satisfaction for meals was scoring low. An audit carried out in January and February 2015 showed that 17% of meals were delivered late into the unit kitchen which then meant that these meals were not adequately hot when served. Further study in May 2015 showed that only 79% of patients received the meals that they ordered. As a result, a series of actions were instigated to try and improve the patient experience in respect of food. These included: encouraging every member of staff to familiarise themselves with the meal ordering system, provision of snack boxes for patients as an alternative and giving patients post cards to feedback their comments about the food.

Pain relief

Critical care

Patient outcomes

- The critical care units participated in a range of national audits such as ICNARC, CCAD, ICBIS (adult critical care transport audit) and the national cardiac arrest audit.
- The general adult intensive care and high dependency units submitted performance data to ICNARC. The majority of cardiac units in the UK do not submit data to ICNARC as their workload is not really comparable with general intensive care practice. As a result the cardiac intensive care unit collected and submitted data on all cardiac surgery patients to CCAD. This provided a comparative measure of cardiac intensive care practice nationally.
- We were provided with the ICNARC data for October to December 2014. The data showed that for the 550 patients admitted in this period, outcomes and mortality were generally within the expected ranges when compared with similar units nationally.
- For all unit acquired infections, the unit performed better than comparable critical care units. In fact, the data for the period October to December 2014 showed that there had been no unit acquired methicillin resistant staphylococcus aureus (MRSA) or Clostridium difficile (C Diff) infections.
- The figures for out of hour's discharges had significantly improved in recent years with just one patient discharged out of hours from the general adult critical care unit in the period April 2014 to September 2015.
- The CCAD data submitted covered activity from April to October 2015 and practice profile data from April 2011 to March 2014. There had been a total of 523 admissions in the period April to October 2015. Coronary artery bypass surgery accounted for 52.7% of the workload. For the period April 2011 to March 2014 the data showed that from 2134 recorded operations there was a risk adjusted survival rate of 97.7%, which was comparable with similar units nationally.
- We were concerned that there was a particular problem regarding delayed discharges from the cardiac intensive care unit and requested specific data in this respect. At the time of writing this report, we had not received this information. The clinical safety dashboard report for July 2015 that was provided did report delayed discharges but at a divisional and not unit level.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been

shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.

Competent staff

- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- Both the general adult critical care and the cardiac intensive care units had designated clinical nurse educators in post who were responsible for co-ordinating the education, training and continuous personal development framework for critical care staff.
- Nursing and medical staff received an annual appraisal. For the period April 2014 to March 2015, divisional records showed that 89% of nursing staff in critical care had received an appraisal in the last 12 months. The trust records for the same period showed that 82% of allied health professionals and 77% of medical staff had received an appraisal.
- 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.
- There was a comprehensive educational programme in place provided by the critical care education team. This included a monthly programme of lunch time teaching sessions. These sessions focused on topics relevant to critical care such as harm free care and infection prevention and control. The education team also provided a range of study days, tutorials, development and competency based training sessions and would assist staff in meeting their revalidation requirements.
- All new staff to critical care were given an induction programme; this was given to them by a practice educator on their first day in the department. The length of this programme depended on prior knowledge of the critical care environment and previous experience. Staff were supernumerary during this induction. The programme lasted from four to eight weeks, or longer if the nurse did not feel ready to go into the staffing numbers. This was supported by an individual action plan.
- A competency booklet was given to all new nurses. A reduced version was given to staff that had previous critical care experience. This booklet followed the individual staff member throughout their induction

Critical care

period. In order to develop clinical experience, new nurses were allocated to work alongside more experienced colleagues. After the induction programme had been completed new staff were then 'buddied' for a further 4 weeks. This is when a member of staff was allocated to oversee the new starter; this process provided support and encouraged team working.

- Nursing staff rotated through the critical care units within their division. So nurses would be rostered to work in the level 3 intensive care unit and then would quite likely be moved to the level 2 high dependency unit after a 6 month period. Staff also moved to the 'high care' unit at Trafford General Hospital.
- 54% of the registered nurses working on the unit had a post registration qualification in critical care. Six staff were currently studying for a critical care qualification and 11 more staff were due to start the critical care course in February 2016.

Multidisciplinary working

- Multi-disciplinary ward rounds took place each day that involved medical, nursing and pharmacy representation.
- There was also evidence of multi-disciplinary working around the discharge of patients involving medical, nursing and allied health professional staff.
- There was a critical care outreach follow up team that aimed to see all patients discharged from critical care within 72 hours. The service included the input of a dedicated physiotherapist who provided additional rehabilitative physiotherapy to patients who needed it. A weekly follow up clinic was also provided, to which patients were invited three months after their discharge. This was in accordance with best practice guidance.
- The education team in critical care worked in conjunction with colleagues in the technical team to provide training on equipment such as ventilators and pumps. They also worked alongside the pain team to deliver training and updates on epidurals, patient controlled analgesia (PCA) and associated guidelines.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy team also provided a seven day service to the critical care unit during the day with an on call service out of hours.

- Dietetic and pharmacy services were available Monday to Friday and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

Access to information

- The critical care unit used a single multidisciplinary paper-based record system but the plan was to introduce a new electronic clinical information system in February 2016. The scale of the transition from paper-based to computer based recording had been recognised. It was expected that an e-learning package would be available for staff by the start of December 2015.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information between relevant health and social care professionals.

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

- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.
- Mental capacity assessment was the specific patient safety focus for October 2015. The hope being that more robust identification of patients lacking capacity would lead to improved identification of patients with delirium, make the identification of patients who required deprivation of liberty referral clearer and ensure appropriate consent for care and treatment. New daily nurse and medical assessment documents had been introduced to support this.
- There was an assessment of mental capacity/delirium recorded in the patient record. The patient safety focus for October 2015 was mental capacity assessment and documentation, which had resulted in the introduction of revised bed side mental capacity assessment tools.

Are critical care services caring?

Good



We rated critical care services 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 general adult critical care (Intensive care and high dependency units) and cardiac units were trialling the use of patient diaries, where appropriate, to help people come to terms with their critical illness experience. Follow up clinics were offered to patients who had been on the unit, three months after their discharge from critical care. There was also a patient stories project being undertaken, where patients were filmed discussing their experience of critical illness and the care they received on the units. These videos were shared across the Greater Manchester Critical Care Network (GMCCN) and shown to staff at monthly clinical effectiveness meetings.

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people with appropriate explanations given prior to care being delivered.
- We spoke with the relatives of patients on all three units. They were universal in their praise for the medical and nursing staff. They told us they had been kept informed of everything that was going on with their relative.
- Patients were actively involved in feeding back their experience of critical care. The patient experience tracker and 'quality care round' questionnaires were being used to collect, collate and present feedback on a range of questions such as 'how clean was the environment?', 'how safe do you feel?', 'are we managing your pain?' and 'do we give you privacy and dignity?' The results were presented monthly to staff in a bar chart dashboard format. For July 2015, the patient experience dashboard for the general adult intensive care unit reported an overall patient experience score of

89.8%. This included a top score of 98.7% for the question, 'are we doing our best to control infections?' and a lowest score of 82.2% for the question, 'do we give you privacy and dignity?'

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment. This was corroborated by a patient that we were able to speak with during the inspection.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- The unit was trialling the use of patient diaries, where appropriate. 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. In addition to trialling patient diaries, the critical care outreach team were also filming patients as part of the patient stories project, where patients talked about their experience of critical illness and the care they received on the units.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a senior nurse for organ donation 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.
- There was a range of initiatives in place to provide support to patients and their families. These included completion of the hospital anxiety and depression score (HADS) and the intensive care psychological assessment tool (IPAT), which helped to determine what interventions might help the patient's psychological health.
- Also included were a weekly follow up clinic, to which patients were invited three months after discharge from critical care. Patients' mobility was assessed using the

Critical care

Chelsea critical care physical assessment tool (CPaX) to help determine the amount of specific physiotherapy input required to assist with their rehabilitation. The follow up physiotherapist also worked closely with other allied health professionals to develop exercise videos. The videos included relaxation strategies from the occupational therapists to help patients with anxieties relating to their stay in critical care.

- The critical care units hosted an annual memorial service for patients and their families.
- The hospital hosted a GMCCN 'Hotline' for relatives to ring should they need any advice. The network also produced a quarterly patients and relatives newsletter, which presented information from all the critical care units in the Greater Manchester network about the dates of on-going initiatives. These included a post critical care support group and volunteer project, where ex patients and relatives would visit current critical care patients to help provide them with support and company, where needed.
- The units ran a memorial service twice a year which was held in the multi-faith centre in the hospital. There was an order of service which included readings, songs, music and a candle lighting ceremony. Refreshments were served after the event with the opportunity for families to meet with staff again from Critical Care. This event was extremely well valued.

Are critical care services responsive?

Requires improvement



We rated critical care services as 'Requires improvement' for Responsive because;

There had been significant improvements in reducing the number of patients discharged out of hours. However, challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. For the general adult intensive care and high dependency units, the ICNARC data indicated performance below the expected ranges when compared to similar units. Both mean length of stay and delayed discharges were worse than compared to similar units. Similarly capacity issues in the cardiac intensive care unit (and wider cardiac wards) meant beds were not always available to allow patients to be discharged onto a ward. These access and flow

pressures had an impact on operational effectiveness. For the period October 2014 to September 2015 there had been 64 cancelled elective cardiac surgery cases as a consequence of there being no available bed.

Patients and their relatives were able to access a nurse led follow up clinic for physical and psychological support following their critical illness. Patients and their relatives were supported in accessing the systems in place for raising concerns and complaints.

Service planning and delivery to meet the needs of local people

- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.
- There were facilities for relatives to stay on the unit if they wished to and overnight, if needed, in bedrooms close by.

Meeting people's individual needs

- Care plans demonstrated that people's individual needs were taken into consideration before delivering care.
- Interpreting services were available within the hospital if required.
- The electronic patient tracking system displayed a variety of information, updated in real time. This included sensitive icons for identifying those patients with particular specialised care and treatment needs such as dementia or a learning disability.
- There was awareness amongst the staff of the delirium that patients can experience as a consequence of being cared for and treated in a critical care environment. Staff used a recognised assessment tool to support assessments of delirium. This was called the confusion assessment method for ICU or 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed once every shift but this was not always evident in the four sets of patient records that we examined. The CAM-ICU utilises yes/no questions for use with non-speaking mechanically ventilated patients.

Access and flow

- Patients were reviewed in person by a consultant within 12 hours of their admission.

Critical care

- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision had been made that a patient was fit for step down or discharge from intensive care there was inevitably a delay. This was the case for the adult intensive care/ high dependency units and the cardiac intensive care unit.
 - Our observations during the visit showed there were patients on the cardiac intensive care unit who were now ready for discharge but there was no bed available. They were ambulant and walking to the bathroom. This was no longer the most appropriate environment for their care and rehabilitation.
 - For the adult intensive care and high dependency units, the ICNARC data indicated performance below the expected ranges when compared to similar units. Both mean length of stay and delayed discharges were worse when compared with similar units. For example, out of 550 patients for the period October to December 2014, 468 (85%) experienced a delay in their discharge. Just over 80% of these patients were delayed for less than one day with very low numbers experiencing a delay of two to five days.
 - In response to the specific access and flow issues in the cardiac intensive care unit (CICU), there was a recognition that the unit needed to improve the accuracy of the information it was collecting. So from February 2015, the unit started to collect data of the same quality as the intensive care units did for their ICNARC submissions. This information was distributed to all staff and was discussed at CICU sisters' meetings. CICU have commenced CICU clinical effectiveness meetings from November 2015 and as part of the regular agenda items the access and flow data was discussed.
 - The length of stay and discharge timeliness had been greatly affected by the four outbreaks of **Carbapenemase-producing Enterobacteriaceae (CPE)** within the Manchester Heart Centre in 2015. This had impacted on bed capacity overall and patient flow, as cohorting of CPE positive patients had been implemented in line with best infection control evidence. A service development business case had been approved by the trust board for additional resources to support implementation of a HDU bed base to improve the flow of patients across all areas of the Manchester Heart Centre (MHC) which will help address delayed discharges and reduce CICU length of stay.
 - The data showed that from February 2015 to October 2015 there had been 187 delayed discharges. The data also contained information about the destination of discharged patients. For the period April to October 2015 out of 523 admissions, 75 (14%) were discharged directly home. This reflected the difficulty the unit sometimes had in discharging patients to a ward.
 - An additional pressure was that the CICU was 'on take' every other day as part of its commitment to assist in providing a primary percutaneous coronary intervention (PPCI) service to the Greater Manchester population. This meant the unit's ability to admit patients was affected by transfers in from other neighbouring Greater Manchester areas. Percutaneous coronary intervention (PCI) is used in the treatment of ischaemic heart disease and involves non-surgical widening of the coronary artery, using a balloon catheter to dilate the artery from within.
 - These access and flow pressures had an impact on operational effectiveness. For the period October 2014 to September 2015 there had been 64 cancelled elective cardiac surgery cases reported as a consequence of there being no available bed.
 - ICNARC data showed there had been low numbers of non-clinical transfers out when compared with similar units. This reflects well on unit performance and indicates that they usually managed to accommodate patients for admission rather than having to move them for non-clinical reasons, like having no available bed.
 - Once discharged from critical care, patients were followed up by the outreach follow up team. The latest available ICNARC data showed that the unit was performing slightly better than comparable units for early readmissions and post unit hospital deaths. Early readmissions are classified as being unit survivors that are subsequently readmitted to the critical care unit within 48 hours of discharge and post unit deaths are classified as being unit survivors that die before ultimate discharge from acute hospital, (excluding those discharged for palliative care).
- ## Learning from complaints and concerns
- The hospital had clear policies and protocols for the management of complaints and concerns. These included defining who was responsible for managing complaints, the timescales for investigations and responses to complainants and the governance

Critical care

pathways through which complaints were reported from ward to board. Learning from complaints, concerns and compliments was triangulated within the division alongside other patient experience and feedback.

- The trust's website contained information on how to raise a concern both informally and as a formal complaint. The website also had a downloadable leaflet with the information required to help patients and their relatives raise concerns. The trust's complaint policy was also available to download.
- We had no specific complaints data relating to critical care in terms of numbers and specific lessons learned. The minutes of the monthly clinical effectiveness meetings had a standing agenda item for complaints but from the three months' minutes we saw, the discussions gave an overview of on-going complaints without any real detail.

Are critical care services well-led?

Good



We rated critical care services as 'Good' for Well-led because;

There was strong clinical and managerial leadership at unit and divisional level. The critical care directorate had a vision and business plan for the next five years. We did not see an equivalent document for the cardiac intensive care unit which sat in a different directorate within the division of specialist medicine.

There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

Critical care services were effectively engaging with staff and patients to inform the improvement and development of its delivery.

Vision and strategy for this service

- The critical care service had a mission statement that set out its purpose and objectives and incorporated the trust wide values of pride, respect, empathy, consideration, compassion and dignity.

- A critical care business plan had been developed covering 2015/16 to 2018/19, which set out the key issues facing the division over the next five years. These covered clinical, operational and financial key challenges. The documents also set out the service development plan milestones, risks and resource requirements, though did not include an update on the progress being made against developmental milestones. For example, there was a service plan for the development of a clinical simulation service to assist with the delivery of clinical education. The developmental plan stated that by quarter 2 of 2015/16 there would be a trust simulation strategy in place. However, whilst the plan set out the inherent risks to achieving this, namely lack of funding and clinical support, it did not indicate whether this milestone had been met or not.
- The critical care business plan also included quality improvement initiatives. For example, making better use of patient experience to drive improvements in quality. The plan also included initiatives to help better meet NHS performance targets such as reducing delayed discharges.
- The aforementioned critical care business plan related to the Critical Care Directorate, which did not include the cardiac intensive care unit.
- Critical care staff were able to articulate the main themes in the business plan.

Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- Monthly critical care directorate clinical effectiveness meetings were held. The minutes showed standing agenda items that included patient stories, clinical risk management (which included a review of incidents with lessons learned), complaints, mortality and morbidity, infection control, pharmacy issues and an audit review. However, we noted that in the minutes provided for May to July 2015 inclusive the audit review agenda item was not discussed.
- The risks inherent with the delivery of safe care were understood and identified on the unit's risk register,

Critical care

which was up to date. The critical care risk register reported at divisional level and also included the risks that related to the cardiac intensive care unit, even though the cardiac intensive care unit sat in a different division. The risk register detailed the risk rating, based on severity and likelihood, along with details of the controls, actions and review dates. The top five risks for the critical care service, all rated as a moderate risk, related to ageing monitoring equipment on HDU, medication errors, the use of agency nursing staff and workforce issues on ICU and the lack of high flow oxygen generators in cardiac intensive care.

- 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.

Leadership of service

- The critical care units all had a designated consultant clinical lead and the nursing team was led by a team of experienced senior nurses.
- There was clear and strong leadership at unit, directorate and divisional levels with staff who had with the skills, integrity, capacity and capability to lead the service effectively.

Culture within 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.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.

Public engagement

- There was some basic and helpful guidance and information regarding critical care on the Manchester Royal Infirmary section of the trust website. This included a brief overview of the services provided, the names of consultant medical staff and contact details for the unit.
- The critical care service was using patient engagement and their experience to improve the quality of the service for future patients. For example, the critical care outreach and follow up team had made educational and instructional videos to which ex-patients had contributed. These were used in developing and

training critical care staff about what it meant to be a patient. There was a specific drive on raising the awareness and understanding of delirium in critical care patients.

- Patient experience was also used in the monthly critical care newsletter produced by the follow up team.
- Ex-patients from the critical care units were lead contributors to the Greater Manchester critical care support group for ex-patients and carers.

Staff engagement

- The critical care service had started to publish a quarterly newsletter entitled 'Crit Care Quarterly'. The first edition was launched in October 2015. The aim of the newsletter was to communicate all the latest news and views from a wide variety of specialities. The October 2015 edition contained many informative articles. For example, there were updates on the trial of patient diaries, the plans for the unit's clinical information system due in February 2016, a section on clinical effectiveness and a staffing update, which brought all staff up to date on the current recruitment issues.
- The critical care service was involved in the trust's wider reward and recognition strategy. Staff were recognised for their contributions to patient care from the perspective of the trust's core values of pride, respect, empathy, dignity, compassion and consideration.
- The cardiac intensive care unit had received a national award for the best student nurse placement for 2015.

Innovation, improvement and sustainability







- Critical Care provided specialist advice and training to support patients and their families as they prepared for major surgery. The critical care unit had introduced innovative programmes that had proved very successful in improving patient recovery from major cancer surgery. For example, the 'Surgery School' and the enhanced recovery programme including 'iCOUGH UK'. 'Surgery School', a patient focused education forum, was introduced in October 2014. Patients scheduled for major elective surgery were invited to attend a one hour educational session which was delivered by a multidisciplinary team. The session included a visit to the critical care units which provided an excellent opportunity to see the environment in which they would be cared for, meet staff and ask questions and share their worries and concerns. iCOUGH was the result of a

Critical care

collaboration between the trust and the Boston Medical Centre where the introduction of a series of simple interventions, such as oral care, coughing and deep breathing exercises, have helped to contribute to a reduction in patient's lung related complications after surgery.

- In the cardiac intensive care unit they had undertaken some specific work to try and reduce the environmental noise and so aid sleep for patients. The results published in May 2015 showed that raising awareness amongst staff of the importance of a calm and quiet environment had seen a 40% decrease in the number of patients disturbed overnight.
- The corridors outside the units displayed posters that illustrated the numerous on-going quality improvement programmes, which included ' Making Meals Matter' alongside various quality dashboards in which patient experience was a clear focus.
- The critical care research team were involved in a number of studies, many of which were centred on the theme of infection. For example, ART 123 – a randomised controlled trial to see whether a new clotting factor saves lives in patients with sepsis associated with coagulopathy.

Maternity and gynaecology

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

Information about the service

St Mary's hospital is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the main trust site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a specialist hospital for women, babies and families. More than 1,400 staff, including doctors, nurses, midwives, scientists, clinical and non-clinical support staff work in Saint Mary's hospital.

The maternity service offers pregnant women and their families antenatal, delivery and postnatal care at St Mary's hospital, Salford birth centre and in the community. Nearly 9000 babies were delivered in the department in the last year. The large antenatal clinic is on the ground floor of the hospital with the other maternity services on the second and third floors. There is a triage service where patients can self-refer or be directed by their general practitioner and an antenatal assessment unit where diagnostic tests can be carried out mainly by appointment. These are adjacent to the 19 bedded consultant led delivery suite, which has one bay of four high dependency beds. There are three dedicated obstetric operating theatres adjacent to the delivery suite. There is one antenatal ward with 20 beds and a corridor with eight single rooms for inductions of labour. There is a midwifery led delivery unit, which has eight birth rooms, including two with birthing pools. There are eight enhanced recovery beds in an area off the delivery suite and 48 postnatal beds situated on two separate wards.

The St Mary's Birth Centre at Salford is a stand-alone midwifery led unit, which had six birth rooms, one poolroom and antenatal clinics. The community midwives provide care to patients in the central Manchester area, Salford and Trafford.

St Mary's hospital also provides a range of specialist gynaecology services for women. Services provided include inpatient care and services within the community. This includes general gynaecology, gynaecology oncology, termination of pregnancy and an emergency gynaecology unit (EGU). The EGU provides 24-hour direct access for patients who have urgent gynaecological problems or women with problems in early pregnancy. The hospital also provides reproductive medicine services and rapid access services for victims of sexual assault. Gynaecology and surgical specialist services such as gynaecology oncology and urogynaecology are offered to those from a wider geographic area. In 2014/15, 16,977 new patients attended as outpatients, 7,763 were treated in outpatients, 3,912 in theatre and there were 12,240 new attendances at the EGU.

The outpatient and diagnostic service offers 15 consultant and nurse-led clinics covering different specialities. The clinics include oncology, post-menopausal bleeding, bladder retraining, nerve stimulation, injection, hysteroscopy, cystoscopy, colposcopy, urodynamics, oncology, menopause, endometriosis, injection (botox) and colposcopy.

Termination of Pregnancy services are provided from the Whitworth Clinic situated within a dedicated area

in the gynaecology outpatient department. The Whitworth Clinic offers a comprehensive range of treatments for

Maternity and gynaecology

women experiencing unplanned pregnancy and for women where a fetal abnormality has been diagnosed up to 19 weeks and 6 days gestation by ultrasound scan.

Contraception for women is also offered. Women living within the Central Manchester area can self-refer or they can be referred to by another agency such as their GP, contraceptive and sexual health services or other organisations. Women outside the Manchester area can also be referred directly to the Whitworth Clinic via their GP or other agencies. Sexual health screening is also offered at the clinic. A counselling service is available for women who need additional support pre and post termination of pregnancy. The clinic is open five days a week from Monday to Friday. Women undergoing medical termination of pregnancy as a day case are cared for in an en-suite side room on the gynaecology ward.

Genomics clinics are also provided in the Manchester centre for genomic medicine, one of the largest and most comprehensive multidisciplinary clinical genetics units in UK. Here, services support pre-natal genetics, dysmorphology, neuromuscular genetics, neuropsychiatric genetics, ophthalmic genetics, cardiac genetics and cancer genetics.

We inspected maternity and gynaecology services as part of our announced inspection on 4 and 5 November 2016 and as part of our unannounced inspection on 26 November 2015. As part of our inspection we visited all areas where maternity and gynaecology services were provided.

In total, we spoke with 26 patients, five relatives/friends and 82 members of staff including doctors, nurses, midwives, ward managers and directorate leads. We observed care and treatment and reviewed the records of 27 patients. We reviewed comments from people who contacted us to tell us about their experiences. We reviewed information provided by the trust and gathered further information during and after our visit.

Summary of findings

We have rated the maternity and gynaecology services as 'Good' overall. However, some areas required improvement particularly in maternity services.

Gynaecology services (including outpatient services) consistently met national access targets. This included referral to treatment times in all specialties. Urgent 2-week referral timescales were also met, and there were rapid access clinics available. Gynaecology services provided effective care with outcomes comparable with, or better than expected standards.

Across maternity and gynaecology services, medicines were safely stored and the necessary records were maintained. Medical and nursing records were accurate, complete, and securely stored. Patient safety was monitored and incidents were investigated to assist learning and improve care. There was an open culture to support the reporting of incidents. There were good systems in place to identify and support patients who were at risk due to social or emotional circumstances. The senior management team was visible and accessible to staff and managers were seen as supportive and approachable. Patients were very positive about the care and treatment they received at the hospital. Staff were committed, passionate about their work, and proud of the services they offered to patients. Staff were keen to learn and continuously improve the services they offered to patients.

Good practice was observed throughout maternity and gynaecology services but increased demand and a high number of staff vacancies led to ongoing challenges in the maternity service. In the maternity unit, there were a high number of incidents reported that were due to staffing issues. Managers were aware of this and recruitment was underway. However although we found staffing levels were adequate at the time of our inspection, the situation was not sustainable and there was limited flexibility in numbers to cope with increased demand, or short notice sickness and absence. Due to the pressures of work, morale was low but staff of all professions supported each other well to work as a

Maternity and gynaecology

team. Medical notes were not always available in maternity clinics and delays in caesarean sections had occurred due to a lack of information. The electronic baby tagging system was not robust.

Bed occupancy rates in maternity services were 25% higher than the England average throughout April, May and June 2015. This meant there was insufficient capacity for the numbers of patients attending the maternity unit. This led to patients waiting to be seen in unsuitable areas, waiting for beds, discharging themselves and delays in treatment.

Are maternity and gynaecology services safe?

Good



We have rated the maternity and gynaecology services as 'Good' for Safe. However, some improvements were required, particularly in maternity services.

There were systems to report and investigate incidents. Staff in all clinical areas were able to describe changes in practice following incident investigations. Most areas of the maternity and gynaecology services were clean and tidy. Staff were aware of current infection prevention and control guidelines and observed good practice. There was a sufficient amount of equipment available in most areas. Medicines were safely stored and necessary records kept. Medical and nursing records were accurate, complete, and securely stored. There were good systems in place to identify and support patients who were at risk due to social or emotional circumstances. There were clear procedures in place to transfer patients between the units including from midwifery led care. While surgical services in maternity were operating safely, there were some concerns about the availability of patient records. There was sufficient medical and nursing staff in gynaecology services to deliver the care and treatment required. Patient safety was monitored and incidents were investigated to assist learning and improve care. There were systems in place for the identification and reporting of safeguarding concerns. Staff worked closely with other organisations to protect and support vulnerable patients. However, the trust's electronic baby tagging system was not robust.

Although we found staffing levels in maternity services were adequate at the time of our inspection, the situation was not sustainable and there was limited flexibility in numbers to cope with increased demand, or short notice sickness and absence. Managers were aware of this and recruitment was underway. Midwives reported not having enough time to meet the responsibilities of their code of practice including timely record keeping. In addition, there could be delays in doctors responding to requests for assessment of a deteriorating patient out of normal working hours. Not all emergency equipment had been checked in line with the trust's policy.

Incidents

Maternity and gynaecology

- There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in the use of the incident reporting system.
- There were 1108 incidents reported in gynaecology services from August 2014 to August 2015. None of the incidents and 'near misses' reported, highlighted any concerns regarding overall patient safety. There were good examples of learning from incidents. Staff in all clinical areas were able to describe changes in practice following incident investigations.
- In maternity services, the specialist midwife with the responsibility for managing incidents told us the top three themes for incident reports were midwifery staffing, absence of medical records and medicine errors.
- Seven serious incidents occurred in maternity services between April 2014 and May 2015. We reviewed the investigation reports and action plans for the three latest incidents. The investigations were comprehensive with action plans that had been implemented. For example, an investigation into a serious incident had resulted in the identification of shortfalls in practice and changes had been made in the use of MEWS (Modified Early Warning Score) assessments and the escalation procedures.
- Staff were encouraged to report incidents; however some maternity staff said they lacked the time to do this with the current pressures of work and relied on the supernumerary band 7 midwives to do this in their area, particularly the delivery suite. This meant not all incidents related to maternity services may be reported appropriately.
- The head of midwifery reviewed all the incident forms for the maternity services. For any incidents, which were graded as severe, an independent review was started within 48 hours. A multidisciplinary panel met weekly to monitor the progress of these investigations and reports. At the review meeting, it was agreed who would be the most appropriate person to lead the investigation. This was dependant on the issue and could be a consultant obstetrician, anaesthetist, neonatologist or midwife.
- There was a quality assurance system in place for all incident investigation reports in maternity services before they were circulated. Two senior members of staff told us they had raised concerns that their incident reports were changed before being circulated and were not always fully reflective of the outcome they had reached.
- There was a weekly maternity multidisciplinary review of incidents within each area, which was open to staff of any grade. Every incident in that area was reviewed at this meeting.
- The managers of each area were responsible for feeding back any learning from incidents to the staff team. A copy of the report was sent to all members of the investigation team, anyone named in the report and a summary was sent to all staff via e-mail. The outcome of investigations and lessons learnt were discussed at safety huddles and ward meetings.
- The supervisors of midwives supported midwives through any incidents they had been involved with using the Gibbs cycle to reflect on the incident and provide opportunities to learn from it in a supportive way.
- There was an "incident of the month" used to highlight how staff had performed well and this was shared via email as a way of identifying positive outcomes from incident reporting.
- The transfer of any patient from the Salford birth centre to St. Mary's hospital was reported and investigated as an incident. If there were any concerns with the care leading to the transfer this was discussed on a one to one basis with the midwife involved and learning shared via email and safety huddles.
- In gynaecology services, mortality and morbidity meetings took place on a 3-monthly basis, staff felt this was sufficient for the levels of activity. These were multi-disciplinary meetings open to all grades of doctor, senior nurses, and ward managers. Individual patient cases were reviewed and lessons learned discussed.
- In maternity services there were monthly mortality and morbidity meetings where stillbirths and neonatal deaths were discussed. This was open to all staff and the minutes were circulated to ensure all staff had access to any actions agreed.
- Avoidable stillbirths were graded as the highest level on the incident scale and all stillbirths were investigated with a resulting report, which highlighted any areas of care that could be improved.

Maternity and gynaecology

- If a patient died at another hospital but had received treatment at St. Mary's hospital at any time, their care was reviewed in order to understand if there was any learning about their part in the care provided.
- There was an initial check with every incident report that the duty of candour regulations had been met. This was a mandatory field in the electronic incident reporting system. Staff were aware of the duty of candour and its requirements. 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

- Patient safety information was displayed in the entrance to wards and clinical areas for patients, visitors and staff to see.
- In maternity services information about harm free care was displayed at the entrance to every ward. This was specific to maternity care and included the number of post-partum haemorrhages and infections. Staff were aware of this data collection and said it was discussed at the safety huddle to assess the performance of the ward.

Cleanliness, infection control and hygiene

- There was a visibly high standard of cleanliness throughout areas delivering gynaecological care. Each of the areas visited had side rooms that could be used to isolate patients if there was a risk of cross infection.
- Staff were aware of current infection prevention and control guidelines and observed good practice. Personal protection equipment such as gloves and aprons was available in all areas.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning activity in outpatient and diagnostic services was recorded weekly on a white board but results were discarded the following week. This meant there were no historical cleaning schedule records for us to review. We were unclear on how staff were able to review this information retrospectively and identify any trends. However, monthly audit scores for outpatient and diagnostic areas between June 2014 and June 2015 showed services were 95% compliant with cleanliness, hygiene and infection control standards.

- Pregnancy remains were handled in line with Human Tissue Authority (HTA) guidelines.
- The areas we visited in maternity services were mostly visibly clean however, some toilets were not and patients told us this had concerned them. This issue had been recognised on some wards and housekeepers had been employed; however, at the unannounced inspection we found some toilets were unclean with debris on the floor.
- On one maternity ward, the patient's survey results for one month showed that 83% of women thought the ward was clean enough. This had increased to 94% following the introduction of the housekeepers on this ward.
- In the obstetric theatres, we observed that masks or glasses were not used although these were available. This did not meet with NICE (National Institute for Clinical Effectiveness) guidance QS49 which states: "Staff should wear specific non-sterile theatre wear (scrub suits, masks, hats and overshoes) in all areas where operations are undertaken".
- Hand hygiene audit results showed there had been increased staff compliance with the expected standard from 70% in October 2013 to 84% in May 2015. We saw staff washing their hands and using the hand gel, which was available throughout all wards.

Environment and equipment

- There were four operating theatres for gynaecological surgical procedures. One theatre was latex free and used to treat patients with a latex allergy. All theatres were visibly clean and tidy and contained the appropriate well-maintained equipment.
- In gynaecology services, records showed that resuscitation equipment in all areas we visited was complete and had been checked on a daily basis.
- Equipment used by gynaecology services such as vital sign observation monitors and fire safety equipment had been maintained and stickers applied to confirm that checks were up to date.
- There were adequate CTG (cardiotocography) machines on the delivery suite however on the antenatal ward, staff reported they had to leave patients to go and find machines and there were not always enough for the number of patients who needed to be monitored. This caused a delay when patients required this form of diagnostic test.

Maternity and gynaecology

- The necessary equipment was present in the high dependency unit in the delivery suite.
- The route of transfer for a woman in labour from the midwifery led unit to the delivery suite was via the public lifts. Staff told us this had never caused a delay as a member of staff would go prior to the patient and ensure the lift was available.
- The two obstetric theatres were adjacent to the delivery suite. One was allocated for emergency surgery and the other for elective caesarean sections. This meant they were easily accessible in an emergency.
- On the maternity unit, not all emergency equipment had been checked in line with the trust's policy. The daily record checks for October 2015 for one of the neonatal resuscitators on the delivery suite had not been completed on nine days. There were five occasions when there was no record that the adult resuscitation equipment on the antenatal ward had been checked.
- Laser treatment rooms in the outpatient areas had appropriate warning signs on the door to stop people from entering when lasers were in use.

Medicines

- Medicines in all areas were securely stored. There were good systems in place for the recording, administration, storage and disposal of medicines.
- Staff had access to the policies and procedures for medicine administration on the hospital intranet.
- On the maternity unit, the system for recording the daily stock check of the controlled drugs did not meet the trusts' policy. This stated there must be a daily check by two staff members that is timed and dated and states "all records checked and correct". We saw that staff had recorded their signature and a date on the cover of the controlled drug record book. This was not a daily entry; it did not indicate what the signature was for and was not timed. This was brought to the attention of senior staff during the inspection and actions were taken to rectify the issue.
- The emergency medicines required in the event of an obstetric emergency such as a post- partum haemorrhage were accessible in all relevant areas.
- Completion of fridge temperature records was sporadic in some areas in maternity services, with only 50% completion in one area for the emergency medicine

fridge. This did not meet with the trust's policy of daily temperature monitoring of these fridges. Similarly, fridge temperatures were not routinely recorded in outpatient services.

- In maternity services, staff had recorded fridge temperatures in one area, which were outside of the accepted range. This had been reported and staff had followed it up with the estates team. No drugs were currently being stored in this fridge.

Records

- All patient care records we reviewed were accurate, comprehensive, dated and signed. This included risk assessments, care plans, medicine records, delivery documentation and care charts.
- However, midwives told us they were concerned that there were times they could not complete their records as quickly as they should following treatment or support. An example was given of labour records being completed over 12 hours after the birth due to the midwife being allocated to other labouring patients immediately. Midwives knew this meant there were potential risks associated with delays in record keeping.
- Assessments of risk such as venous thromboembolism were documented in the patient records we reviewed.
- Organisations that carry out a termination of pregnancy are legally required to report them to the Department of Health. We reviewed three completed copies of the required documentation and found that all had been completed correctly and within the required timescales. The documentation was signed appropriately by two doctors in accordance with the legislative requirements. There was good practice in documenting the reasons for the termination of pregnancy.
- There were comprehensive risk assessments for patients who had not booked their pregnancy with the hospital but arrived in labour.
- The condition of the paper medical records in maternity services was poor. Documents were not always filed chronologically and loose papers were present. This could lead to loss of essential information and we observed delays in identifying important records such as the latest safeguarding record.
- Records were securely stored which protected the confidentiality of patients' information.

Maternity and gynaecology

- The community midwives had been issued with hand held tablet computers so they could access test results and any other electronic patient records. They said this improved the timely access to test results.
- In gynaecology services there was a combination of paper and electronic records in use. We looked at eight sets of paper records and three records in the new electronic format. The records provided complete information about the care pathway and were readily accessible. However, we noted that the digital and paper systems did not communicate in any way; staff confirmed this made cross-referencing a patient's journey through the hospital difficult.

Safeguarding

- Information provided by the trust showed 93% of staff at Saint Mary's hospital were up to date with level one safeguarding training and 90% were up to date with level two training.
- There were three specialist safeguarding midwives. They provided training and support to midwives and medical staff who could refer a patient to them if they had any safeguarding concerns. This team would then refer to other agencies as necessary.
- In maternity services, the midwives sought consent from any patient with a history of mental illness to refer them to the safeguarding team. The team could offer ongoing support and guidance throughout the patient's pregnancy and following the birth of their child.
- There were links with an independent domestic abuse advisor and midwives were aware of how to access this support when required. Staff at the Whitworth clinic worked closely with the trust's Sexual Assault Referral Centre (SARC), in order to support women who may need to access the clinic after experiencing sexual violence or abuse.
- Policies had been developed for Female Genital Mutilation (FGM) and the trust was proactive in working with victims of child sexual exploitation.
- Midwives had worked with police to identify pregnant women who may be the victims of people trafficking. They were developing this work with other agencies in the area.
- If a patient did not attend for clinic appointments at the Salford Birth Centre on three occasions a referral was made to the safeguarding team for follow up.

- There was a formal documented handover of care from the safeguarding midwives to the health visitors. This ensured continuity of care and support.
- In maternity services, we reviewed safeguarding reports held in patient records. These contained sufficient information for staff to understand the concerns and the management plans in place. In gynaecology services, there were good examples of staff acting promptly and appropriately to secure the safety and welfare of children.
- Staff said there was a lack of availability of the baby security tags. Information provided by the trust showed there were times when insufficient tags were available. On one occasion there were 14 babies not tagged on one ward and on another, staff were unable to find tags for 17 babies. At the time of our unannounced visit there were 20 babies on one ward and four did not have a security tag fitted. We were told two of these could not have one fitted due to contraindications with therapy they were receiving.
- The doors to the various maternity wards and units were locked and opened by video link to the reception area or the ward. We were told by senior midwives that there were concerns regarding people who had not announced their arrival following others onto the ward ("tailgating").
- We observed an alarm sounding on one ward and staff did not respond for several minutes until the ward manager prompted them. This alarm was a baby security tag, which had sounded as it had become dislodged; however, the lack of response showed staff had not reacted appropriately to a potential risk to a baby.

Mandatory training

- There was a robust system in place to remind staff when their training was due which included informing their line manager if a staff member did not attend training as arranged.
- At the time of our inspection mandatory training completion levels for staff were 91%(nursing), 80% (medical), 95% (administration and managerial) and 71% (laboratory staff). In addition to this, 80% of nursing staff and 72% of medical staff had undergone resuscitation training across the gynaecology division. The trust's target for mandatory training completion was 90%.

Maternity and gynaecology

- At the time of our inspection, mandatory training completion levels for maternity services was 86% for clinical mandatory training and 88% for corporate mandatory training.
- However, the trust's system did not provide individual managers with easy access to their staff's training status in maternity services.
- There was limited time for midwives to keep up to date with their on-line training and they were advised to do this in their own time. One of the effects of the challenges with midwifery staffing was that three maternity mandatory training dates had to be changed resulting in staff not being up to date with this training. On one of these dates, the training had to be stopped due to staff being required in the clinical areas.

Assessing and responding to patient risk

- There were clear guidelines for the assessment and management of care for both high risk and low risk patients. In gynaecology services, general health checks were carried out in the preoperative clinic, such as weight and blood pressure. Further investigations would be completed on a risk assessment basis (for example, if the patient had an underlying medical condition).
- In gynaecology services, there were systems in place to ensure that patients received prompt medical assessment and support should their condition require it. This included the high dependency care unit (HDU) if necessary. For example, when a patient was identified as deteriorating by nursing staff, their concerns were immediately escalated to a member of the medical team who provided a review and updated treatment plan.
- Records confirmed the risks of complications after surgery were assessed and acted upon appropriately preoperatively and postoperatively.
- In the maternity records we reviewed, the obstetric early warning score had been accurately completed and was used appropriately to identify the deterioration in a patient's condition. This had been escalated when appropriate to ensure the patient was transferred from the midwifery led unit to the delivery suite during labour.
- Some midwives were concerned they could not always complete the necessary observations to detect

deterioration in a patient's condition due to a shortage of staff on the wards. Staff said such instances were reported as an incident, however we did not find any incident reports related to this.

- In maternity services, there could be delays in doctors responding to requests for assessment of a deteriorating patient out of normal working hours. In a record we reviewed, assessment by a doctor had been requested via the bleep system at 2.45am and despite two further requests it was 4.30am before they saw the patient due to being busy on another ward.
- Staff on the maternity high dependency unit could access support and advice from the intensive care team of nurses and anaesthetists who would visit the unit and assess patients when required.
- There was a good system for the transfer of care between the maternity high dependency unit and the general intensive care unit. We saw examples of where patients had been moved between the two units following an assessment of their condition and communication about their needs was clearly recorded.
- There was a clear emergency transfer protocol for a patient in labour on the midwifery led unit requiring transfer to the delivery suite for consultant led care. Midwives told us they would accompany the patient to the unit and continue their care during delivery. This meant the patient received continuity of care.
- Protocols and procedures for managing deteriorating patients were available for staff in outpatient and diagnostic services. This included a designated contact number for requesting assistance during medical emergencies. There were two resuscitation trolleys in the outpatient department and a defibrillator in the main reception area.
- There were arrangements in place to ensure checks were made prior to, during and after maternity and gynaecological surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' guidelines. All steps were being followed during our observations, however records we reviewed in relation to maternity services showed these checks were not fully recorded. In the four notes we reviewed for post caesarean sections, two records had been fully completed, one was partially completed and for one patient the record was not present. The checklists we looked at in gynaecology services showed that all the stages were completed correctly.

Maternity and gynaecology

- Cell salvage was used in theatre. This is a medical procedure that involves recovering blood lost during surgery and re-infusing it into the patient. This reduced the need for blood transfusions.
- There was a comprehensive risk assessment pathway in the hand held maternity notes. This meant if a patient came to the maternity unit any risks were easily identified by staff who may not know them.
- There was a clear protocol for the emergency transfer of a patient from the Salford birth centre to the delivery suite at St. Mary's hospital. This was facilitated using a blue light ambulance and informing the maternity emergency bleep holder at the hospital of the imminent transfer. A midwife from the birth centre would accompany the patient and handover their care giving all necessary information at the hospital.
- No incidents had resulted in harm to patients as the escalation procedures had been put in place and the movement of staff had ensured patient safety.
- Some practices constituted "red flag" events in line with NICE guidance (NG4) "Safe midwifery staffing for maternity settings". There were delays in inductions of labour due to insufficient midwife numbers and we were told of delays in washing and suturing patients following delivery.
- Midwives were concerned they were unable to work within their code of practice due to conflicting demands on their time and the care of patients with complex medical needs. There were staff accounts of patients not receiving epidurals during their labour and incident reports highlighting midwives caring for multiple patients with complex needs, unable to carry out observations and administer prescribed medicines. At times midwives did not have the time to support distressed patients and complete records in a timely way.

Midwifery and nursing staffing

- In gynaecology services, nurse staffing was reviewed throughout the day and staff between ward areas and EGU were allocated based on patient need. This meant the workload and staffing could be assessed on an ongoing basis throughout the day to ensure patients' needs were met.
- Staff reported that due to vacancies and maternity leave, staffing levels in EGU would sometimes fall below the trust's recommended minimum staffing levels. Staff felt there was no flexibility to cope with additional staff absence and increased patient attendance numbers, which had the potential to impact on patient safety. Data received from the trust prior to inspection confirmed that the trust were aware of the risk and had developed a staff recruitment plan in order to address the staffing issues on EGU.
- The midwife to birth ratio was reported by the trust to be 1:24 in May 2015. During the inspection staff said it was 1:15; however, we saw there were staff shortages in all areas due to sickness, maternity leave and posts awaiting recruitment.
- In the past three months there had been 58 incidents reported in maternity services due to staffing issues. On one occasion, there were nine midwives on the delivery unit of which six were newly qualified midwives and there were four patients in the high dependency unit. Incident reports identified that the number of staff and the skill mix were insufficient and could potentially put the care of patients at risk. Other incidents showed similar challenges with staffing and skill mix.
- Whilst there were an agreed number of midwives required in each area, there was a system of assessing the need throughout a 24-hour period. The midwife who carried the emergency bleep for the unit would move midwives and support workers between areas to provide cover based on need and patient complexity. This meant areas such as the enhanced recovery bays and post-natal wards often had less staff than planned in order to ensure that the delivery unit was adequately staffed.
- Redeployment of staff to the delivery unit could then lead to staffing shortages in other areas. On one occasion, there were two midwives on the postnatal ward to care for 20 women and 16 babies. This included eight patients who were receiving additional treatment due to their clinical condition. There were eight induction of labour rooms on the antenatal unit and there were eight midwives allocated to this area. However, we were told two were usually present in each area with the others being moved to the delivery suite and the theatre recovery area. Staff described this as unsafe at times due to the complex nature of the patients' condition and the degree of monitoring the patient and unborn baby required.

Maternity and gynaecology

- Midwives in the triage area were often moved to the delivery suite with a woman in labour if they presented in the unit. They were then expected to stay with that patient during labour, which reduced the staff numbers in the triage area.
- Information provided by the trust for planned versus actual numbers of midwives showed there was a shortage of between 28% to 34% of midwives on day shifts from July to September 2015. The number of actual shifts filled was 68.7% for midwives and 58.4% for care staff on day duty in September 2015. This does not take into account the actual numbers on each unit once staff had been redeployed. Whilst there was up to 34% unfilled shifts, action was taken to mitigate the risks to ensure safe care. However, this was having an impact on the responsiveness of the service and we have reported on our findings on this under the 'Responsive' section of the report.
- Recruitment of midwives was underway and there was a planned increase from 315 to 345. At the time of our inspection, there were 23 offers of employment made however, there would be a delay for 16 of these due to them needing their Nursing and Midwifery Council registration prior to starting work.
- The outpatient staff sickness rate was 14% at the time of the inspection. The manager told us this was unusual and that rates were usually between 3% and 4%. It had increased because of long term sickness but staff were due to return the following week. Staff responsible for managing rotas covered sickness by increasing part time worker hours in agreement with staff, rather than using bank or agency staff. For this reason, bank and agency staff use was low.
- Information provided by the trust showed sickness rates on the delivery unit had increased from 1% in April 2015 to 7% in September 2015. Midwives felt the increase was in part due to the workload on the unit.
- Despite the shortage of staff particularly on the delivery suite, patients received one to one care during labour. However, staff needed to leave the patient quickly after birth to support another patient in labour. This was not good practice as there was no continuity of care after birth.
- The senior midwives on call out of hours would attend the unit if required due to staff shortages. One manager told us they had been on call four times in two weeks

and they had been called into the unit twice. This showed that the system for additional support worked in practice; however, the need for additional staff was more frequent than would be expected.

- Maternity support workers were employed to assist the midwives with tasks such as breast feeding support, providing meals and assisting patients with hygiene needs. Both patients and midwives said their support was essential with the shortages of midwives in most areas.
- There was recognition that retention of band 5 midwives was difficult and there were a variety of reasons for this, some of which were outside of the control of the service. However measures had been put in place to encourage retention which included a thorough preceptorship package, two weeks supernumerary working and support in the their first year of work.
- In maternity services, written handover records were used in most areas that provided comprehensive information for each shift. However, when midwives were redeployed during a shift, they did not always get a thorough handover.
- There was a formal recorded handover at each shift change on the gynaecology wards and in the theatre department. There was opportunity to discuss the care required by a patient with the staff member who had been responsible for their care on the outgoing shift.

Medical staffing

- There were 16 gynaecologists employed by the trust including four urogynaecologists, 3.5 gynaecology oncologists, one in paediatric gynaecology with the remainder specialising in fertility and endometrial conditions.
- The gynaecology medical on-call rota meant consultant cover was available at all times including out of hours. Consultants were on the hospital site for at least 6 hours on a Saturday and Sunday, and provided on-call cover out of hours.
- Discharges were facilitated over the weekend if this was required. A senior registrar was on duty at other times to provide emergency treatment during on-call hours. All medical staff we spoke with said consultants would always attend to perform emergency surgery out of hours. Junior doctors told us they found this supportive.
- Medical cover for outpatients was provided by each speciality. Most clinics were led by consultants although some (such as colposcopy clinics) were nurse led.

Maternity and gynaecology

- There were 168 hours of consultant presence on the labour ward. This was seen as an outstanding amount of senior medical cover and this hospital was the first in the area to introduce it.
- Outside normal working hours there were two registrars and two junior doctors available in addition to the consultant obstetrician. However, there were times when the volume of patients meant there were still delays with medical reviews and treatment.
- There were three consultant anaesthetists available for maternity services. One covered the delivery suite from 8am to 9pm, another covered the high dependency unit from 8am to 6pm and the third covered the caesarean section theatre list from 8am to 6pm. Outside of these hours, junior doctors were on call who had support from more senior doctors on current placement at the hospital. This meant there was good anaesthetic cover available at all times.
- The use of locum doctors was low at 6.5% of obstetric consultants and 5.9% of other doctors in the obstetrics and gynaecology service.
- Medical handovers took place, which were multidisciplinary and included all necessary medical staff. There was discussion about any incidents, the work for the day and any learning opportunities for junior doctors.

Major incident awareness and training

- Major incident training was delivered to staff as part of 'level one' mandatory training. 93% of all staff (except doctors and allied health professionals) and 92% of allied health professionals had completed this training. Only 74% of doctors had completed the training against a target of 90%.
- In maternity and gynaecology services, managers and other staff were aware there was a major incident policy however, they were unaware of any role they may have within it. The exception to this was the outpatient service. The outpatient department was not a designated major incident patient area but staff were familiar with policies and procedures should a major incident be declared.

Are maternity and gynaecology services effective?

Good



We have rated maternity and gynaecology services as 'Good' for Effective because;

In gynaecology services, care and treatment were delivered in accordance with evidence-based guidelines, standards and best practice. The service had a system for receiving, recording, assessing and monitoring compliance with guidance from the National Institute for Health and Care Excellence (NICE).

Patients accessing gynaecology services had good outcomes that were in line with or better than the national average. The outcomes for maternity patients in most modes of delivery were in line with the England average. Policies and procedures were up to date and accessible for staff. There was a robust plan for auditing practices and procedures, which included review of any agreed actions. There were good systems in place for the adequate nutrition of patients and support for infant feeding. Newly qualified midwives were well supported. There was good multidisciplinary working across maternity and gynaecology services. Women were provided with information, which helped them to understand their treatment and care before consenting to any proposed treatment.

However, in maternity services, the practices for induction of labour did not meet current guidance. Most patients received pain relief in a timely way however, this was not always achieved in some areas. Completion of specific maternity skills and drills training did not meet the trust's target and not all staff were up to date with emergency training. Medical notes were not always available in clinics and delays in caesarean sections had occurred due to a lack of information.

Evidence-based care and treatment

- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. Policies, guidelines and protocols were available for staff to access on the trust's intranet site.

Maternity and gynaecology

- The guidelines we saw were up to date and based on current guidance such as NICE (National Institute for Clinical Excellence) and the Royal College of Midwives.
- Staff followed a national work instruction for the counselling of women prior to termination of pregnancy and best practice, following Department of Health required standard operating procedures (RSOPs) and RCOG clinical guidelines for medical termination of pregnancy.
- There were specific care pathways used for termination of pregnancy using evidence based methods in order to standardise and improve the care for patients.
- We reviewed records which confirmed that the disposal of fetal remains followed the Human Tissue Authority Code of Practice.
- Induction of labour practices did not meet NICE guidance (CG70) as women were not offered induction of labour between 41 and 42 weeks to avoid prolonged pregnancy. Although the policy was to offer induction within this timescale, in reality the lack of capacity and shortage of midwives led to patients waiting beyond this timescale to have their labour induced.
- There was evidence that research studies were used in the development of guidelines, for example in the care of the perineum of labouring women.
- There was an audit plan, which was monitored monthly within maternity services and quarterly within the division. This was consultant led and audits were agreed and allocated to an appropriate doctor of varying grades or midwife as part of their development.
- In gynaecology services, senior staff took part in national and local audits to ensure they were providing care in line with recognised standards. These included the national menorrhagia audit and a local audit to investigate the recurrence rate of infections with Bartholin's gland surgery. The results were comparable with other similar organisations.
- An audit on the use of CTG had been completed in September 2014. This had shown that the CTG was not being reviewed once an hour and they were not all being reviewed by the 'fresh eyes' buddying approach as per the trust's policy. An action plan had been developed and the systems for reporting had been reviewed. It had been found that when doctors reviewed a CTG on the computer system it did not register as "fresh eyes" which had affected the results. This was due to be re-audited in November 2015.
- Robust action plans were completed following audits and progress was discussed at the clinical effectiveness meetings.
- A team of senior midwives, consultants and supervisors of midwives had been set up to benchmark the care against the recommendations of the Kirkup enquiry. The development of the satellite units and staff rotation had been identified as areas for further development.
- Staff within the division, participated in an extensive programme of local, national and internationally recognised research. In areas such as female genital mutilation (FGM), senior staff within St Mary's Hospital were participating in the development and implementation of national guidelines.
- Senior midwives in the trust contributed to the regional normality working group and brought information back to the staff to enhance their working practices. The provision of a stand-alone midwifery led unit and a second one alongside the consultant led care gave opportunities for patients assessed as low risk to have as normal a birth as possible. This met with the Royal College of Midwives guidance on normality.
- However, due to a lack of capacity on the midwifery led unit, patients who had chosen this route would need to go through the general maternity triage system if they attended the hospital in labour or with concerns about their pregnancy. Midwifery led pathways for common uncomplicated problems were not in place. This meant patients were then part of the consultant led pathway of care, which they had chosen to avoid if possible.
- In gynaecology services, clinical pathways had been developed to guide surgical practice. These included the 'Enhanced recovery integrated care pathway for laparoscopic gynaecological surgery 24–36 hour clinical pathway'. This meant there was clear guidance for staff, based on nationally recognised guidelines, for the care and treatment of patients having surgical procedures.
- A bereavement steering group met every two to three months with staff from the neonatal unit, pathology, midwives, doctors and clerics. They discussed specific patients to assess for learning and monitor the bereavement service being offered. Any feedback was provided directly to the midwives via email or at supervision.

Pain relief

Maternity and gynaecology

- The review of complaints from April 2014 to May 2015 showed one of the themes in obstetric care was inadequate pain relief.
- However, the majority of patients in both maternity and gynaecology services said their pain and analgesia administration had been well managed.
- In gynaecology services, procedures were in place to ensure that patients received pain relief as soon as needed following surgery. These included pre-assessment discussions with the patient. There was a notice displayed in the obstetric theatres to remind staff to prescribe pain relief prior to the patient being returned to the ward. This showed there was an emphasis on providing timely pain relief.
- Assessments of pain were recorded as part of the nursing observation of day patients in the recovery areas and on the gynaecology wards.
- Patients attending the outpatient and diagnostic services were offered a range of supportive interventions during procedures to help minimise any pain. These included the use of heat packs and patient distraction techniques. Pain relief such as paracetamol was also available.
- On the postnatal ward, patients had provided feedback that they had to wait for their pain relief and the system had been reviewed as a result. The storage of one type of medicine had meant there were sometimes delays in obtaining keys to access the medicine when required. The storage system had been reviewed and changed by the pharmacy department to aid timely access to medicines.
- Midwives told us there were sometimes delays in epidurals being administered. In one example from a divert report, a patient had requested an epidural however, due to there being no bed available on the delivery unit, they remained on the antenatal ward where their baby was born with the aid of alternative pain relief. This meant the patient did not get the pain relief she had requested and her birth experience was not the one she had chosen.
- If required for patients with complex needs, the trust's pain management team could be consulted for advice and support 24 hours per day.
- Staff described how they addressed people's religious and cultural needs regarding food.
- Staff assisted patients who needed support with eating and drinking, and did so in a dignified and sensitive manner. Whenever possible, there was a period during meal times when activities on the wards stopped, if it was safe for them to do so, so staff could provide patients with additional support if required.
- Patients reported the food was good and snack boxes were available so that patients had access to food outside the normal meal times. On one ward, the quality dashboard showed that 89% of patients had agreed that good nutrition was offered.
- The trust had obtained 'Baby Friendly' level three status. Stage three was the final stage of assessing the implementation of the 'baby friendly' standards. This was part of the United Nations International Children's Emergency Fund of the United Kingdom (UNICEF UK) 'Baby Friendly Initiative'. The initiative worked to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.
- Patients told us they had good support for breast-feeding, particularly from the maternity support workers.
- Patients were given a choice of how to feed their baby and those who chose not to breast feed were given support with their choice.
- A secure fridge was available for the storage of breast and formula milk. There was a procedure for the safe labelling and storage of this milk.
- Community midwives discussed how they would support a patient who felt they might stop breast-feeding. They would visit them to advise and support them with specific issues or guide them to the breast-feeding support group and clinic.

Patient outcomes

- In gynaecology services, the average length of stay for patients after surgery was better than the England average. For elective surgery, it was 1.2 days compared to the England average of 3.3 days. For non-elective surgery, it was 1 day compared to the England average of 5.2 days. It was difficult to compare these figures equally given the specialist nature of the gynaecology directorate and the diverse nature of the services it offered. However, overall this data showed that patients were able to leave hospital in a timely way to recover at home without their discharge being delayed.

Nutrition and hydration

- People were given a choice of suitable and nutritious food and drink, and we observed hot and cold drinks were available throughout the day.

Maternity and gynaecology

- The outpatient and diagnostic services participated in various local audits, for example annual audits were completed about care for women requiring emergency contraception. This audit showed yearly improvements for key objectives such as offering screening for sexually transmitted disease and completing documents relating to intrauterine devices during appointments.
- The modes of delivery including elective and emergency caesarean sections were in line with the England average.
- The trust had previously been identified as an outlier for puerperal sepsis and other infections as part of the CQC intelligent monitoring programme. On request, the trust had provided the CQC's maternity outliers panel with the requested information and could evidence that a full investigation had taken place to understand the data and identify areas for improvement. As a result the service had an action plan in place and this had reduced the rate of infection from 6.8% to 4% between April 2015 and July 2015.
- There was an enhanced recovery programme for patients following a caesarean section. This was a specific area of the delivery unit with dedicated staff and a clear programme of care to achieve discharge within 24 hours of delivery where clinically possible.
- The induction of labour rate had risen to 30% following introduction of new pathways for reduced fetal movements and intrauterine growth restriction. This had resulted in a reduction of stillbirths from 1% of births in April 2015 to 0.5% in July.
- The home birth rate was 0.3%. There was a working group in place to identify why the numbers were low and investigate ways to increase it.
- There had been no unplanned admissions to the general intensive care unit between April and July 2015.
- Information provided by the trust showed that between November 2014 and October 2015, 154 patients who had a maternity high dependency unit episode had been readmitted within 28 days.
- Transfers from the midwifery led unit to the delivery unit were between 6% and 10% between August 2014 and July 2015.
- The post-partum haemorrhage rate was below 2.5% between April and July 2015.
- Third and fourth degree tears had reduced from 3.7% in April 2015 to 2.3% in July 2015.
- Staff received annual appraisals where performance and development was discussed with a line manager. Annual figures showed that the trust had improved the appraisal rates for all relevant staff groups (except allied health professionals and medical staff) from 51% between April 2012 and March 2013 to 96% between April 2014 and March 2015.
- The Central Treatment Suite had British Society for Colposcopy and Cervical Pathology (BSCCP) accreditation. This meant that women were cared for by appropriately trained staff.
- Locums and junior doctors attended maternity simulation training as part of the specific maternity skills and drills training.
- In October 2015 78% of doctors, midwives and maternity assistants had completed the maternity specific skills and drills mandatory training, this was below the trust's target of 90%. Not all staff were up to date with emergency training. For example, only 59% of doctors were up to date with neonatal resuscitation, 56% of midwives and 58% of doctors with blood administration assessments and 70% of midwives and 69% of doctors with fetal heart interpretation and formal/informal CTG. This meant staff may not be up to date with the knowledge and skills necessary to assist patients in an emergency.
- All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training.
- The induction for locum doctors included a tour of the unit with location of key equipment identified. Their first instrumental delivery and caesarean section were supervised by the consultant on call.
- New midwives completed a two week induction, which maternity specific training and competence assessments for monitoring of patients and diagnostic testing. They also had information sessions with the specialist midwives including the bereavement, infant feeding and screening midwife and an introduction from the head of midwifery.
- New staff told us the thorough induction programme prepared them well. They had ongoing support following this and one midwife told us the practice midwife had visited them on the ward to offer support and monitor progress.

Competent staff

Maternity and gynaecology

- The preceptorship period for newly qualified midwives was 18 months to two years and included multidisciplinary workshops, mentor support and assessments.
- In most areas of the maternity services, there were a combination of core staff who always worked on that area and rotational staff who moved around and worked in all the areas. It was not mandatory to rotate and this meant some staff did not work in areas such as the delivery suite in order to keep up to date with the necessary skills. When staff were moved between wards due to a shortage of midwives, they were at times in an area where they were not up to date with current practice.
- The core staff on the midwifery led unit rotated to the delivery suite for one month every year. This was identified through supervision and appraisal and meant midwives had some opportunity to work in a setting with more complex deliveries.
- Midwives who worked on the maternity high dependency unit had completed three days theoretical training, three days shadowing staff in the general intensive care unit and completed competence assessments. There was an intensive care trained nurse on the unit 24 hours a day, which met with Royal College of Obstetrics and Gynaecology guidance: "Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman."
- The lead midwives used the roaming "quality bus" to go around the wards and highlight specific areas of practice for staff. This served as a short learning opportunity for a specific topic.
- Operating department personnel worked in the obstetric theatres with midwives. This meant the midwife assisted in the recovery and care of the baby and did not work as a theatre assistant.
- Community midwives rotated into the Salford Birth Centre for four months every year. This helped them keep up some skills that they may not otherwise use regularly.
- The midwifery assistants on the community were trained to assist the midwife if there were emergencies such as a breech birth or a post-partum haemorrhage.
- Midwives were encouraged and supported to complete the training for the examination of the newborn. This meant midwives had the opportunity to extend their role.

Multidisciplinary working

- We saw a good example of a multidisciplinary clinic in gynaecology services that was held monthly. The clinic was specifically designed to include the attendance of specialist clinicians to provide care to patients with complex sexual development needs. This required the input of more than one specialist, such as an endocrinologist and other health professionals including gynaecologists and psychologists.
- The department of genomic medicine held a range of clinics involving multi-disciplinary teams such as renal genetics, neurofibromatosis and skeletal dysplasia clinics.
- Staff on the gynaecology wards gave examples of when other health professionals had been part of the care planning for a patient, such as for a patient with learning disabilities.
- Medical, nursing and ancillary staff all described good multidisciplinary working. All of the staff we spoke with where highly complementary, saying everyone communicated well across the various disciplines.
- Without exception, midwives of all bands told us they worked very well as a team, supporting each other through very busy times with the welfare of the patient at the heart of everything they did.
- Both midwives and doctors told us there was good communication and cooperation between them. Both spoke highly of the other and described being part of one big obstetric team. Midwives valued the support workers and how they provided assistance with a variety of tasks in the very busy maternity units.
- We saw good written communication for patients who were transferred between wards in the maternity unit. This included records of care received, risk assessments and management plans.
- There was a clear pathway for patients who required transfer to the high dependency unit from another ward in the maternity service. This included an assessment with the midwife, consultant obstetrician, consultant anaesthetist, critical care nurse and medical input from any other speciality involved in their care.
- Where patients required specialist input for their pregnancy due to complex medical issues they were seen as soon as possible in their pregnancy in the antenatal clinic. Agreement was then reached with the patient and existing medical team as to who would lead on their care.

Maternity and gynaecology

- On the post-natal ward, the neonatal team visited daily to assess any babies about whom the midwives had concerns. There was a good working relationship between these two disciplines with open communication and clear working practices to ensure babies were appropriately reviewed.
- In the high dependency unit, there was easy access to specialist medical support such as cardiology, haematology and urology.
- Community midwives spoke about the good links they had with specialist practitioners for vulnerable women in the community. This included social services and the voluntary sector as well as specialist midwives from the trust.
- There were two specialist diabetes midwives who received referrals from GPs, antenatal clinics and ward midwives about women with pre-existing diabetes or newly diagnosed patients. They saw patients monthly for scans and they had a growth scan every 3 to 4 weeks throughout their pregnancy. They worked with staff in the hypertension clinic and the clinic for patients with a high body mass index to offer appropriate assessment and care to patients through their pregnancy.
- The Department of Health RSOPs state that women should have access to a 24-hour advice line which specialises in post termination support and care. The Emergency Gynaecology Unit (EGU) provided post termination support and advice 24 hours per day, seven days a week. Rapid access to treatment was also offered via the EGU.
- An on call physiotherapy service was also provided at the weekends, which meant that patients continued to receive the same standard of care at weekends.
- There was an on call pharmacist service available to provide support across the division out of hours.
- We found suitable access to imaging and pathology out of hours. Scans were available in the antenatal assessment unit by midwives qualified to complete them. When they were not available or there was no sonographer present, they could access scans via the emergency department.
- The antenatal assessment unit was open Monday to Friday from 8.30am to 8pm and Sunday from 9am to 5pm. Between these times patients were seen at the triage department which meant they had access to midwives 24 hours a day, seven days a week.
- Antenatal clinics ran Monday to Friday from 8am to 6pm. There had recently been some clinics held on a Saturday however staff were not aware of plans for this to become a regular clinic.

Seven-day services

- Outpatient clinics operated Monday to Friday between 8:30am and 5pm. Services were not operating at the weekend at the time of our inspection; however, plans were in place to provide them in the future. This was co-ordinated through a seven-day service steering group, which kept staff informed through a dedicated intranet website and an engagement event held in July 2015.
- Planned gynaecology surgery took place between Monday and Friday. Extra slots had been made available to deal with patients who needed surgery in a shorter time frame to improve patient outcomes. Outside these hours, sufficient staff were available, either within the hospital or on call, to carry out emergency procedures as required.
- Consultant cover was available at all times in gynaecology services. Doctors completed visits to the wards on both Saturdays and Sundays, and supported timely discharge.
- There were two teams of qualified operating department personnel available 24 hours per day. They were responsible for assisting during operations in the obstetric theatres.

Access to information

- Staff across maternity and gynaecology services could access the latest information relevant to their service.
- In maternity services, information provided by the trust showed there were occasions when patients' medical notes were not available. This was particularly the case in antenatal clinics where, at Salford antenatal clinic on one occasion, there were 50% of the notes missing. It was documented that there had been delays in caesarean sections due to notes not being available.
- A working party had been set up to investigate the issue of missing notes at the outpatient clinics. A resulting action plan had been implemented with timescales for completion of October 2015. This included joint working with the medical records team. Despite this staff in the antenatal clinic confirmed there had been two sets of missing notes on the day of our inspection and this occurred at every clinic.

Maternity and gynaecology

- Whilst most patients carried their hand held notes when attending the hospital related to their pregnancy, some did not and due to the complexity of some patients' condition, their medical notes were required to safely carry out a consultation.
- Junior doctors said medical notes were available most of the time in gynaecology outpatient clinics. An audit conducted by the trust for June and July 2015 showed that 93% of records were available at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Written consent was obtained prior to surgical procedures. Evidence supported that verbal consent was gained for procedures such as internal examinations. Records confirmed that patients were given appropriate information regarding the risks and benefits of the procedure that had been offered to them.
- Consent for caesarean sections had been completed fully in the records we reviewed.
- Staff were aware of their role and responsibility regarding the care and support of any patient who lacked mental capacity. They had received training regarding this and would use the specialist mental health or safeguarding leads for advice and support.
- Key staff or 'champions' acted as leads in outpatient areas for care relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. These staff had additional training to identify patients who required care under these circumstances.

Are maternity and gynaecology services caring?

Good



We have rated the maternity and gynaecology services as 'Good' for Caring because;

Care and treatment were delivered to patients in a person-centred and sensitive way. Patients and those close to them were extremely positive about the caring and supportive attitudes of staff. Patients described nursing staff, midwives and maternity support workers as very

caring, considerate, helpful and kind. Family and Friends Test results showed the majority of patients would recommend maternity and gynaecology services to their friends or relatives.

Patients and their partners/relatives were active partners in care, and patients told us they felt involved in the decision-making process. People's individual preferences and needs were reflected in how care was delivered. Care was delivered with kindness and compassion.

In maternity services, we heard call bells ringing for a considerable time before being answered; however, patients did not feel there had been delays in getting assistance. There were good systems in place for emotional support of patients, particularly following the death of a baby. Support was provided for patients with mental health or emotional needs.

Compassionate care

- In gynaecology services, patients told us that nursing staff were kind and patient. Patients said they were well cared for and had been treated in a sensitive manner.
- In maternity services, the patients described the midwives as very caring, kind and helpful.
- One patient in the high dependency unit told us the staff "go that extra mile to check you are ok". They felt well cared for by the midwives.
- Patients said their privacy and dignity were respected. Privacy curtains were used around patient beds and staff were quick to assist patients when their privacy could be compromised.
- In maternity services, we heard call bells sounding for long periods without staff responding to them. Patients did not feel they had to wait too long before a member of staff came to assist them, however they did comment that the staff were very busy so they understood if there was a delay.
- Of those patients who completed the NHS Friends and Family Test in January 2015, 100% said they would recommend the gynaecology services to others.
- The maternity services had a mixed performance from the Friends and Family Test with the antenatal unit scoring both 100% and 0% on multiple occasions for patients who would recommend the ward.

Maternity and gynaecology

- The postnatal ward performed similar to the England average, and both birth and postnatal community provision (PCP) were frequently better than the England average with PCP scoring 100% for eight months out of 12.
- The trust's score was similar to others for all the questions in the CQC Maternity survey.

Understanding and involvement of patients and those close to them

- Staff were observed explaining procedures and involving a patient in decision-making. We observed staff explaining why an examination of a patient was required. We noted staff giving time for questions and answering any concerns raised.
- In gynaecology services, staff were seen providing reassurance and explanations to partners and relatives. Relatives described feeling included and involved in the care of their partners. For example, one patient told us how the staff had not only supported her, but had 'gone out of their way' to ensure that both her partner and children had access to the services who could support them. The patient told us how knowing her partner and children were being cared for emotionally had been a great source of comfort. The patient commented: "I don't know how we would have coped without them [staff], every single one on this ward has just been wonderful. I couldn't have asked for better care..... and not just for me. All of them are just amazing. I know I couldn't have gotten better care anywhere."
- Between January 2014 and January 2015, staff in outpatient areas at St Mary's (excluding maternity and termination of pregnancy services) scored 100% when observed communicating with patients and relatives, 95% of patients felt happy with the service they received, and 87% of patients felt happy with the amount of information provided during appointments.
- All of the staff we spoke with in gynaecology services said that if a patient required a relative to be with them because of anxiety or any other need, they would facilitate this if possible.
- Patients told us the visiting hours were flexible and their partners were able to be present during their stay as necessary.
- There had been a recent trial for partners to remain on the induction of labour bay at all times. This trial was currently being evaluated.
- One patient's partner had stayed for five nights during and following the birth of their baby. Whilst they had been made welcome by staff who had been very helpful, the facilities offered were "not great" with only a small couch for sleeping on.

Emotional support

- The level of support offered to patients in St Mary's outpatient areas was measured as part of assessing patient experience. Between January 2014 and January 2015, 94% of patients in outpatient areas (excluding maternity and termination of pregnancy services) reported being told who they could contact if they felt worried about their treatment or condition once they arrived home from their appointment.
- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were skilled and sensitive in supporting patients and those close to them during difficult and stressful periods.
- Staff were skilled at building trusting relationships with patients and their relatives within a short space of time. Patients and relatives told us that they received considerable emotional support from all members of the multidisciplinary teams involved in their care.
- One patient praised the midwifery support staff for their kindness when they had required emotional support following an illness of their newborn baby.
- The bereavement midwives provided teaching sessions for midwives and doctors about how to support bereaved parents.
- Following a stillbirth, parents were offered various memory making options including entry in a remembrance book, hand and foot prints and ongoing bereavement support and counselling. The bereavement midwives also assisted with the practicalities such as registration and funeral arrangements.
- There was a confidential email that bereaved parents could use to access support following the death of a baby or stillbirth. The bereavement midwives would offer support and guidance in a way which was led by the wishes of the parents. There was an open invitation to attend bi-monthly coffee mornings for ongoing support if required. These were well supported with 45 people attending the last event.
- The bereavement midwife offered emotional support to parents at their next pregnancy if they had experienced a stillbirth previously.

Maternity and gynaecology

- If abnormalities were detected on a scan, emotional support for parents was offered throughout the pregnancy by a specialist midwife.
- Emotional support from various religious denominations was available including Jewish, Buddhist and Humanist.
- Questions regarding a patient's mental well-being were asked during the first appointment. A referral to the specialist mental health midwife would be made if there were concerns or a history of anxiety or depression.

Are maternity and gynaecology services responsive?

Requires improvement



We have rated maternity and gynaecology services as 'Requires improvement' for Responsive because;

Bed occupancy rates in maternity services were 25% higher than the England average throughout April, May and June 2015. This meant there was insufficient capacity for the numbers of patients attending the maternity unit. A policy to divert patients to other units in the area was in place however, the threshold for the use of this policy was not clearly defined and there was no risk assessment to support the process. The lack of capacity and staffing challenges led to patients waiting to be seen in unsuitable areas, waiting for beds, discharging themselves and having treatment delayed. There were significant delays for patients who required an induction of labour. The system was to plan eight inductions per day, however due to bed capacity and staffing, these were often not completed on the day. This led to some patients being admitted to wait for induction and others being sent home to wait. Patients went beyond the planned date of term plus 10 days with examples of patients still waiting at term plus 18 days.

The gynaecology service responded to the diverse needs of the local population by providing services where gaps had been identified. Joint working with other organisations had resulted in improved access to services and outcomes for patients. Gynaecology services (including outpatient services) consistently met national access targets. This included referral to treatment times in all specialties. Urgent 2-week referral timescales were also met and there

were rapid access clinics available. The service also provided a locally unique gynaecology emergency unit that offered 24-hour access to emergency care and did not require a doctor's referral.

Patients' religious and cultural needs were met and there was an interpreter service available for patients whose first language was not English. Patients knew how to complain and there was a system to review and learn from complaints. The systems for discharge had been reviewed and changes made to facilitate more timely discharge where possible.

Service planning and delivery to meet the needs of local people

- There was a high teenage pregnancy rate in the geographical area served by the hospital. There were three young people's midwives who liaised with the teenage pregnancy team to support young patients through the management of their pregnancy and after care.
- The termination of pregnancy service offered a fast track appointment system for women with higher gestational age or those with any complex needs.
- The outpatient reception area was situated in a large atrium on the ground floor and was bright and spacious. The phlebotomy clinic area was less so due to being an internal room without natural light. There was adequate seating in the main waiting area but phlebotomy staff told us queues often formed for blood tests in the phlebotomy room.
- A part time midwife supported patients who were seeking asylum in the area. They worked with other agencies to ensure patients received appropriate care and support.
- The St Mary's birth centre could be accessed by patients who had a Salford postcode only. This was in line with the contract from the commissioners of the service however, it limited its use and the number of births there were low. Patients who were entitled to attend could access antenatal and post-natal clinics, which meant they had all the midwifery led maternity services they needed, close to home.
- Following birth by caesarean section in the obstetric theatres, the baby was wrapped and taken to an adjoining room for the initial checks to be completed. Midwives told us this was due to the temperature in the theatre and a lack of space in the theatre for the

Maternity and gynaecology

necessary equipment such as weighing scales.

Information provided by the trust showed the ambient temperatures were recorded in one of the two obstetric theatres however, the outcome of this monitoring was not provided. If the baby needed to be admitted to the neonatal care unit, the mother would not see the baby prior to this admission. Midwives were aware this could be distressing for a patient and it did not meet with Royal College of Midwifery guidance.

- On the antenatal ward, patients told us they could hear other patients within the four-bedded bay when they were in early stages of labour. There were insufficient side rooms to accommodate these patients therefore they were waiting for a room on the delivery suite.
- The gynaecology services at the hospital provided treatment for women living in the Central Manchester area local to the hospital. Specialist gynaecology surgery services, such as urogynaecology, gynae-oncology and reproductive medicine were provided for women who could be referred to the hospital from a wider geographical area. This increased the diversity of patients who attended the hospital and this was considered when planning the service.
- The gynaecology emergency unit was locally unique in that it allowed patients to refer themselves to a specific unit for assessment and treatment of gynaecological emergencies and problems in early pregnancy.
- Gaps in service provision for local people were considered in the planning of gynaecology services. An example of this included the development of a specialist endometriosis clinic that gave women with this condition an opportunity to see multidisciplinary specialists.
- A surgical day gynaecology service was introduced to reduce the need for patients to be admitted to theatre or as an inpatient. This clinic provided a prompt and accessible service for patients who did not need to stay in hospital overnight.
- The maternity ward areas were light and spacious with wide corridors and a mix of single room and four bedded bay accommodation. Due to the high number of patients, some areas such as the triage and the day assessment unit did not provide adequate seating for waiting patients. This led to them waiting in corridors.
- The gynaecology services provided a wide range of information, which supported patients and their relatives to make decisions about their care and treatment and the services available to them.

Access and flow

- Bed occupancy rates in maternity services were 25% higher than the England average throughout April, May and June 2015.
- The maternity unit had been on divert six times in September and October. The unit was part of the Greater Manchester maternity network with other local maternity services. The North West Divert and Deflection policy was used within this group to reduce closures of units and instead divert activity to other units. This had occurred within the escalation policy of the hospital when the activity was too great for safe patient care to be assured.
- Managers, midwives and doctors told us the escalation policy worked in practice with non-clinical midwives working on the wards, community midwives and those on their days off coming in and others staying late to help. However, the threshold for implementation of the divert policy was not clearly defined and there was no risk assessment to support the process.
- There was a triage area in the same ward as the delivery suite. This was staffed 24 hours per day by three midwives and a support worker. They provided telephone and face-to-face support and advice. The protocol was for patients to be seen within 30 minutes by a midwife and medical review within one hour if they needed to be assessed by a doctor. Approximately 40 to 50 women were seen per day, which made this a very busy area. There were delays for patients out of hours who needed to see a doctor. Incidents reported there had been delays of up to several hours at busy times due to no doctor being allocated to this area after 5pm. During that time, the doctors on the delivery suite would be required to see the patients. An audit into the delays had begun recently but no results were yet available.
- There were significant delays for patients who required an induction of labour. The system was to plan eight inductions per day, however due to bed capacity and staffing, these were often not completed on the day. This led to some patients being admitted to wait for induction and others being sent home to wait. Patients went beyond the planned date of term plus 10 days with examples of patients still waiting at term plus 18 days. According to the divert report, there had been 19 patients waiting for induction at one time. One patient had waited for five days with reduced fetal movements. Although these patients were seen daily by a consultant

Maternity and gynaecology

and had twice daily fetal monitoring and were prioritised based on their clinical need, we saw the delay had led to patients being distressed and discharging themselves from the hospital. This put the patient and unborn baby at risk.

- The number of patients waiting to be discharged contributed to the capacity challenges. The system had been reviewed and twice-daily ward rounds had been introduced as well as midwife led discharge for low risk patients. Whilst this had increased the timely discharge for some, patients were not discharged overnight and therefore there was usually a backlog in the mornings.
- There was no procedure for outpatient inductions of labour. A senior midwife had begun working on the induction of labour ward to assess the current procedures and identify new ways of working to reduce the waiting times. This work had not started at the time of inspection.
- There were plans to address the environmental capacity to accommodate patients for induction of labour, which would mean allocating part of the delivery suite to induction of labour bays. However, the pressures of work had prevented this being implemented.
- In order to aid the flow of patients through the unit, 8% of midwives had completed training in the examination of the newborn. This meant they could complete the necessary checks prior to discharge without the need for the patient to wait for a paediatrician.
- The enhanced recovery bays were open Monday to Friday 24 hours per day with patients being discharged on Saturdays when they reached 24 hours post operation. This area was used for post-natal patients most weekends when there was no capacity on the post-natal ward. This meant alternative beds had to be found for these patients on Monday morning or they had to be discharged before caesarean sections could be carried out. We were told no caesarean sections had been cancelled due to lack of capacity; however, there were delays due to lack of bed availability.
- Bed occupancy on the gynaecology wards varied throughout the week with midweek being the busiest at around 98% occupancy, reducing to 40–50% at other times. Staff said they could always access a bed on a ward should they need to.
- Gynaecology services consistently met national access targets. This included referral to treatment times in all specialties for example the cancer targets of 31 and 62 days). Urgent 2-week referral timescales were also met and there were rapid access clinics available.
- The average time taken for patients to be referred for treatment at St Mary's outpatient department between February and July 2015 was 4 weeks. This was better than the department of Health target of 18 weeks.
- At the time we inspected St Mary's outpatient clinic area, patients told us there were no delays in waiting to be seen following arrival. We reviewed 27 patient feedback forms from September 2015 all of which confirmed this.
- Senior staff told us that 15% of patients did not attend colposcopy clinics. To improve this, the hospital introduced a dedicated colposcopy service administration team, who contacted patients by phone or text to provide a reminder of appointment details. This had reduced the rate of patients not attending appointments to 10%.
- Senior staff told us outpatient clinics were only cancelled in exceptional circumstances such as short notice sickness absence. We asked the trust to tell us how many clinics were cancelled but they were unable to provide this information for all clinics. However, they described measures to limit the need to cancel clinics such as restrictions on booking leave six weeks prior to clinic dates.
- Discharge information was communicated to GPs and community nurses when women were discharged from gynaecology services. Discharge summaries were written and sent to GPs to ensure they were aware of the care and treatment given.
- Department of Health standard operating procedures for termination of pregnancy services state that women should be offered an appointment within five working days of referral and they should be offered a termination procedure within five working days of the decision to proceed. Data confirmed that 79% of women could have an appointment within five days from referral to consultation. 86% could have the procedure within five working days from decision to proceed to treatment. However it was noted that some women needed extra time in which to make a decision about whether to proceed.

Meeting people's individual needs

Maternity and gynaecology

- An interpreting service was available either in person or via the telephone. Staff told us this was efficient and most languages required could be accessed. Staff were aware of the limitations of using family members to interpret for patients.
- There was no hearing loop in the main reception area of St Mary's outpatient department for people who used hearing aids. However, staff had received deaf awareness training.
- The bereavement midwives said they would use face-to-face translation services wherever possible as this was more suitable than a phone line for discussions they had with parents.
- Specialist midwives were available seven days per week to provide advice and support for patients with mental health issues or drug and alcohol dependency. There were two consultants with a special interest in this area who held weekly clinics and a perinatal psychiatrist attended a weekly multidisciplinary clinic. In gynaecology services, there were processes in place to support women with mental health concerns. Staff were able to describe the process they would use to access consultant psychiatric support.
- There was a record in a patient's notes if they had a learning disability and specialist requirements to meet their needs were documented.
- In maternity services, the management of a patient with learning disabilities began at their first appointment when a referral to the safeguarding team would be made and an antenatal plan of care was established. The plans for discharge and community midwife involvement would begin as soon as possible. An example was given of a patient with a learning disability who had remained an inpatient following the birth of their baby in order to receive parent craft support such as preparing feeds, bathing and positioning for sleep.
- Alternative forms of communication, such as pictures, were used where necessary to ensure the patient was included in their care and was offered choices.
- The gynaecology service had developed a specialist service relating to developmental sexual dysfunction. This clinic met specific needs of patients suffering a variety of sexual development issues. Patients who attended this clinic had the opportunity to be seen by consultant gynaecologists, endocrinologists and psychologists. Counselling services were also available.
- A review of the complaints at St Mary's hospital between April 2014 and May 2015 showed the highest number were in relation to the obstetric services at 37.4%. However in context they were the busiest unit in the hospital. Themes were extracted from the information and shared with managers who passed this information to staff in their area.
- Patients said they would raise concerns or complaints if they wanted to and knew how to do this. We noted that Information on how to complain was displayed throughout the hospital.
- There was a system in place and a commitment from staff to learn from complaints.
- There was evidence that negative comments from patients and visitors were acted upon to make improvements in the service. One example was that housekeepers had been employed on specific wards in response to adverse comments about cleanliness.
- There had been only one complaint in the past 12 months at the St Mary's Birth Centre. The details of this complaint were shared with staff via email and in the safety huddles at shift handover.

Are maternity and gynaecology services well-led?

Good



We have rated maternity and gynaecology services as 'Good' for Well-led because;

Throughout maternity and gynaecology services, there was a clear leadership structure and strategies were in place for monitoring the quality of the care provided. The trust's vision and values were well known throughout the gynaecology services. All staff we spoke with in gynaecology services were aware of the service's priorities and challenges, and understood the plans and actions needed to address them. The gynaecology dashboard had been developed, giving a snapshot of important indicators that were used to monitor performance, quality and safety against set targets. Risks within maternity and gynaecology service were discussed regularly at both ward and divisional level. There was a ward accreditation scheme, which was a trust wide system for measuring the quality of

Learning from complaints and concerns

Maternity and gynaecology

the service provided on each ward. The managers and midwives we spoke with said they knew how to improve aspects of their service to meet a higher level and were proud when they had achieved a good score.

However, there were ongoing challenges within maternity services. Some staff were not aware of a vision for the maternity services although there was a five-year plan in place. There was an open culture where staff could discuss concerns and ideas with their managers; however, staff in maternity services felt there was limited action as a result. Due to the pressures of work in maternity services, morale was low but staff of all professions supported each other well to work as a team.

Vision and strategy for this service

- Most staff were clear on the organisational vision and strategy. There was a clear focus on the provision of women-centred care within the division.
- Managers and other staff we spoke with said the vision of the hospital was to provide good care to all patients regardless of the complexity of their condition. Those we asked were unaware of any plans to manage the growth in births experienced at the hospital, which had resulted in the current staffing and capacity pressures.
- Senior staff at St Mary's outpatient department spoke about their vision for improving quality and a team was in place to manage this on a rolling basis. Actions to improve quality included the introduction of patient notice boards to improve communication, and the creation of 'champions' who, through additional training, led in areas such as learning disabilities, safeguarding, domestic abuse, alcohol dependency and the Mental Capacity Act.
- Midwives at the Salford birth centre told us they were concerned about the future of the unit due to the low number of births there, but were unaware of the future strategy for the service.

Governance, risk management and quality measurement

- The gynaecology dashboard had been developed, giving a snapshot of important indicators that were used to monitor performance, quality and safety against set targets.
- Risks within the services were discussed regularly at both ward and divisional level, and escalated when necessary.

- Monthly directorate clinical effectiveness meetings took place where risks to be added to the directorate risk register were discussed. Discussions regarding progress on action plans and decisions for issues to remain on the register or to be removed were also part of these meetings.
- There were also divisional clinical effectiveness meetings where monthly feedback on the quality of the service from each directorate was discussed with resulting agreement on the actions to be taken. The topics included patient feedback, actions against targets for audits and guideline reviews, management of risks and clinical outcomes.
- In maternity services, managers, midwives and doctors consistently told us the main risk was a shortage of midwives. Although recruitment was underway, there were concerns this would not be sufficient or timely to manage the risks and that current actions did not adequately mitigate the risks to patients on a daily basis.
- There were initiatives to share and raise awareness of risk management with more staff. This was done by sharing the risk reports with band 7 midwives and developing a risk newsletter for the whole unit to enable band 5 and 6 midwives to be aware of the management of risks.
- There was acknowledgement from the managers that the turnover of staff in maternity services led to difficulties in embedding change where this was required.
- There was a ward accreditation scheme, which was a trust wide system for measuring the quality of the service provided on each ward. The managers and midwives we spoke with said they knew how to improve aspects of their service to meet a higher level and were proud when they had achieved a good score.
- Termination of pregnancy records we reviewed confirmed that regular internal audits of HSA1 forms were undertaken by the service. This assured us that robust monitoring arrangements were in place, to ensure compliance with legal obligations relating to termination of pregnancy.
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 forms). The HSA4 forms were reported electronically to

Maternity and gynaecology

DH on the same day following the termination procedure. The HSA4 forms were signed online within 14 days of the completion of the abortion by the doctor who terminated the pregnancy.

Leadership of service

- Divisional management were described as visible, approachable and supportive. All staff we spoke with were positive about the support they received from senior staff within the gynaecology directorate.
- Staff on the wards told us they attended regular staff meetings, which they found valuable, and that their immediate line managers were accessible and approachable.
- We saw some examples of good leadership by individual members of the medical and nursing staff in gynaecology services who were positive role models for staff.
- Junior and middle-grade medical staff were enthusiastic about the leadership provided by the senior medical team.
- In maternity services, band 5 and 6 midwives in most areas told us the managers were supportive and would assist them by working in a clinical role when required.
- There were career progression opportunities for band 6 midwives, which included education links for experience and rotation into managerial roles.
- Band 7 midwives told us they worked clinically in their area and this meant their allocated time for management duties was reduced.
- Staff in maternity services told us the leadership of the service in most areas had improved. This included the appropriate management of individual staff whose behaviour was not consistent with the expectations of working in the trust.

Culture within the service

- There was an open and positive culture across the gynaecology services. Staff told us the positive open culture within the directorate, promoted loyalty and teamwork among the medical and nursing teams.
- All areas of the maternity service were extremely busy. Despite the pressures of work staff were under, the midwives of all grades, doctors and other staff were very focused on providing the best service they could to the patients.

- There was a culture of teamwork in maternity services, which many midwives told us was the reason they still worked at the trust. We observed staff supporting each other including across professions and grades.
- Midwives and other staff told us they could discuss any concerns they had with their line manager. They said there was an open culture where they felt able to speak out.

Public engagement

- In the community, hand held tablet computers were given to the patients for them to complete the friends and family test immediately following the provision of care.
- Some wards also had a hand held system, which could be used for patient feedback but others did not. Patients we spoke with had been asked for informal feedback in most areas but few had been encouraged to give formal feedback.
- The Clinical Commissioning Group had not set up a maternity services liaison committee in the area. There was no other system in place for patients to become involved in the development of the maternity services.
- The bereavement midwives used feedback questionnaires about the emotional support provided which were given to parents with their consent. They then used this feedback to improve services; speaking face to face with specific staff members to improve the service if possible.
- There was public engagement through the St Mary's charity. Through the charity, the people who use the service and the wider public in general, had taken part in numerous fund raising activities.

Staff engagement

- All qualifying members of staff were automatically invited to become 'Staff Members' of the trust. This gave staff the opportunity to play an active role in developing quality services for both patients and staff including the opportunity to have an input into trust strategy. For example, 'Staff Members' had the opportunity to vote for staff governors to sit on the trust's Council of Governors.
- There were mechanisms in place to keep midwives informed which included a three monthly newsletter, emails, care huddles and team meetings. Managers and midwives agreed that attendance at team meetings was difficult due to the staff shortages and pressures of work.







Maternity and gynaecology

- We were told maternity staff were expected to attend 50% of team meetings, however due to the pressures of work, finding time to attend meetings was difficult. Staff therefore attended in their own time and did not get time back in lieu of this. Staff were unhappy with this and did not feel managers listened when they discussed the difficulties in accessing these meetings.
- Both formal and informal mechanisms for supporting staff through difficult situations was available. This included formal counselling or less formal debrief sessions as a group or one to one. Staff said there was always someone to access to discuss any emotional issues arising from their work.
- In some areas of the maternity services, individual staff members had been supported and encouraged to be innovative and develop practice ideas; however, they agreed this had become difficult since the growth of the service which meant their workload had increased.
- The use of social media as a vehicle to communicate with staff and patients was well developed and effective.
- St Mary's Hospital had developed an enhanced recovery programme; this was a new approach to the care of patients following a surgical procedure. Information reviewed prior to inspection showed this was an evidence-based approach where different members of the hospital and primary care team worked together in order to ensure that patients were in the best possible condition before their operation, better prepared for their hospital stay and able to feel better sooner after their operation.

Innovation, improvement and sustainability

- There was a 2016 – 2019/20 obstetric directorate business plan. This included the clinical and quality aims, objectives and challenges for the next five years of the service with an action plan of how to achieve the improvements identified.
- Managers in maternity services told us their greatest challenge was to meet the demands in the growth of the service. The current environment was not designed to meet the needs of the current numbers of patients or for the predicted future growth.
- The outpatient department used 'mystery shoppers' to ensure staff met objectives such as answering phones within five rings. The data was used in local audits and action was taken to address issues identified. For example, repositioning telephone points to enable staff to answer calls more quickly.
- The urogynaecology department in St Mary's outpatient department was a UK speciality training centre for pelvic floor care and accepted referrals nationally as well as locally.

Neonatal services

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

Information about the service

The neonatal intensive care unit (NICU) is situated on ward 68 at St Mary's Hospital. St Mary's hospital is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the main trust site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a specialist hospital for women, babies and families. The unit is governed by the directorate of newborn intensive care services.

The neonatal service provides both neonatal medicine and surgery and is a referral centre for the Greater Manchester area. The unit is a level three neonatal intensive care unit (NICU) with a 59-cot capacity spread across eight separate rooms. The unit is connected to the delivery suite at St Mary's hospital.

The unit provides care and treatment to all premature and sick infants requiring level one, two and three care and accepts infants requiring surgery, with the exception of cardiac surgery. Babies requiring cardiac surgery are transferred to specialist units. There are approximately 1000 plus admissions to the neonatal unit each year.

We visited all areas on the neonatal unit including parent's accommodation on the unit as part of our announced inspection on 4 and 5 November 2015. We interviewed the clinical director, senior nurse managers, 13 nurses of different bands and experience, a research and education support nurse, a fetal screening coordinator, two health care assistants, allied health care professionals, one middle grade doctor, a unit administrator, a volunteer and a

chaplain. We talked with the parents of five babies on the unit. At the time of our inspection, there were 17 babies in intensive care, 15 in the high dependency unit and 27 in special care cot provision.

We reviewed information in 10 sets of care records, three care pathway documents and ten policies and procedures. We observed care and interactions between staff, patients and relatives. Evidence, such as audit results, reports and notes from meetings provided by the trust were also reviewed during the inspection.

Neonatal services

Summary of findings

We have rated neonatal services as 'Good' overall because;

Treatment was based on current best practice guidance and was constantly reviewed to ensure that care met the needs of the baby and identified ways to improve treatment. The service responded to the outcomes of audits and worked collaboratively with other units, research agencies, royal colleges and universities both nationally and internationally to make sure the best possible outcomes were achieved. Patients and parents were supported by a team of specialist nurses who worked in a co-ordinated way to provide care, advice and support throughout the baby's admission. Parents were treated well and involved in the care of their babies. They were positive about their experiences. We observed compassionate care that promoted the wellbeing and future emotional development of babies.

The neonatal team included highly skilled expert practitioners. Staff had opportunities to maintain their competencies and develop additional skills. Nurses were consistently deployed according to best practice guidance, seven days a week and a consultant neonatologist was on site 24 hours a day, seven days a week. There were two consultants and a range of specialist support such as specialist nurses available at weekends. Staff complied with infection control measures and the environment and facilities on the unit were clean, well maintained and promoted the safety of babies. Adequate and appropriately maintained emergency equipment was available to quickly meet the needs of deteriorating babies.

The service fostered an open culture and provided training and guidance to staff to ensure they were able to raise all incidents and concerns. Processes were in place to effectively deal with concerns raised. Investigations were robust and action was taken to prevent repeat incidents and ensure lessons learnt were shared with staff and appropriate changes made. The direct leadership team were motivational, focussed and effective in supporting staff and involving stakeholders in relation to providing a good service. There were robust governance systems in place to monitor performance and promote improvements.

Are neonatal services safe?

Good



We have rated neonatal services as 'Good' for Safe because;

There were robust systems in place for reporting, investigating and learning from incidents. The service took action to prevent harm to patients in their care and ensured infection control protocols were followed. The environment was clean and well maintained and medication was stored, prescribed and monitored to promote safe administration.

There was a well-established safeguarding protocol, which was understood by staff and involved a multidisciplinary approach to concerns identified at any stage of the baby's admission. Nursing and medical staff were deployed in sufficient numbers and with relevant skills to meet the needs of babies and parents on the unit. Training was provided to ensure staff could respond appropriately to medical emergencies.

Incidents

- The trust used an electronic incident reporting system accessible to all staff including locum doctors who were given temporary access codes. Computers were accessible throughout the unit, including by each cot which enabled immediate reporting.
- Staff were aware of policies, procedures and their responsibilities in relation to reporting incidents. The policy included a reporting matrix, which helped staff to decide what to report, the level of risk to record and actions to take.
- We reviewed incident records for children and young people (CYP) and maternity. These included reports made about the neonatal service. Between 20 August 2014 and 19 August 2015, 545 neonatal unit incidents, including near miss, reports had been made.
- All staff groups in the neonatal unit reported incidents. This demonstrated that staff across the neonatal unit participated in promoting the safety on the neonatal unit by reporting incidents, which were brought to the attention of senior staff.
- We reviewed two root-cause analysis (RCA) investigations completed by the senior management

Neonatal services

team. An RCA is a systematic investigation of adverse incidents, which can identify system failures and areas for improvement. Information showed RCA investigations had been carried out by appropriately trained and a comprehensive, in-depth exploration of the events had been completed. The documents also included action taken since the incident, the lessons learnt and how this would be shared with individuals, groups or trust wide.

- The progress of incident investigations, outcomes and plans relating to sharing lessons learnt were monitored at monthly neonatal clinical effectiveness meetings. Attendees included the risk manager, and senior medical and nursing staff.
- Different methods were used to share lessons learnt with all staff. Examples included the trust's intranet pages, quarterly neonatal newsletter, neonatal unit monthly staff meetings, the message of the week feedback process, a monthly 'practice point' publication from the risk management and education team and unit huddles.
- These forums were also used to share findings from all meetings so that staff who could not attend were kept informed.
- Records showed that separate mortality and morbidity meetings were held monthly. The reasons for stillborn babies and babies who were unwell when born, were discussed. The attendance list from the meetings in May, June and July 2015 indicated these were well attended by staff of all nursing and clinical grades.
- The trust provided a clear duty of candour protocol and staff were aware of how to inform parents about safety issues, which had affected them or their baby. 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.
- Records indicated that the policy was used and parents were kept informed when required through phone calls, face-to-face meetings and letters.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used to measure patient harms and 'harm free' care. Neonatal services can choose whether to develop this tool and if they do, what outcomes to measure. This information forms a snapshot for a particular period of care during each month.

- The neonatal service participated in this initiative and information on display showed there had been no incidents of pressure ulcers, falls or slips, Methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C. Diff) infections on the unit between April 2015 and October 2015.
- However, the September 2015 quality dashboard, which was another safety measurement check, reported five low-grade pressure ulcers had occurred between February and June 2015. This was confirmed by incident reports submitted by staff. The incidence of pressure ulcers had been due to the equipment needed to help baby's breath or monitor their vital signs.
- The review of reports, action plans and discussion with staff identified that reducing the number of pressure ulcers was a priority concern for doctors and nurses on the unit. There were processes in place to monitor medical equipment in use and minimise risks of pressure ulcer damage.
- Information about safety was on view but it was not very accessible to visitors because the display board contained a lot of information presented in very small print.

Cleanliness, infection control and hygiene

- The Department of Health code of practice on the prevention of infections and related guidance was followed within the neonatal intensive care unit.
- Although there were no cases of hospital acquired MRSA or C.Diff on the neonatal unit in the 12 months prior to the inspection, there had been an outbreak of infection called Serratia.
- Records indicated that appropriate steps had been taken to locate the source and contain the outbreak. Action had been taken to treat the infection and weekly blood tests were being completed to make sure infection control measures were effective.
- The service had strengthened their infection prevention measures to reduce cross infection. This included ensuring babies were nursed in isolation, cots were cleaned three times a day and more robust and frequent hand hygiene audits had been completed monthly.
- Hand hygiene audits included all staff and visitors to the unit including parents. Hand hygiene audit reports for the neonatal unit indicated a minimum of monthly

Neonatal services

checks between April 2014 and April 2015. During the year, compliance ranged between 67% and 100%.

Non-compliance was addressed with individuals at the time or an action plan put in place if required.

- Hand-gel and personal protection equipment (PPE) such as gloves and aprons were conveniently placed throughout the unit and by cots as required.
- All staff we observed adhered to the 'bare below elbows' dress code and demonstrated good hand-hygiene techniques.
- The results of the 2014 national neonatal audit program (NNAP) showed the neonatal unit at St Mary's hospital achieved a lower than average rate of blood stream infections. The England average for these infections was 3.32 per 1000 central line days, the neonatal unit at St Mary's hospital scored 1.56 per 1000 central line days.
- The trust had a service level agreement with a company responsible for maintaining the unit. Cleaning schedule and reports indicated systems were in place to ensure that a high standard of cleanliness was maintained.
- Clean equipment was labelled and dated so staff knew when items were safe to use. All equipment and areas of the unit were visibly clean and tidy.

Environment and equipment

- The 2015 trust environmental summary report showed that the neonatal unit passed all checks relating to lighting, flooring and fixtures and fittings.
- The service had completed a comprehensive review of the environment on the neonatal unit to ensure the needs of the babies were met. Rooms facilities provided the appropriate environment in relation to light and noise levels.
- Equipment and incubators for each cot space was checked at the beginning of every shift to make sure they were clean, complete and fit for purpose.
- Equipment was available to deal with neonatal and adult medical emergencies. There were two neonatal emergency trolleys and one adult emergency trolley on the neonatal unit. Each trolley held the equipment recommended by the UK Resuscitation Council and records confirmed daily checks had been completed. We reviewed the equipment and medication on each trolley and all items were in date and fit to use.

Medicines

- Medication on the neonatal unit was stored safely. Controlled drugs were kept in a locked cabinet within a locked treatment room. Signatures and recorded medication counts confirmed twice daily checks were completed by two nurses.
- We reviewed five medication charts, staff had recorded the weight of each baby, and the medication to ensure the correct medication was given in the correct dose.
- The unit used an electronic prescribing system to ensure the medication prescribed was appropriate, this enabled best prescribing to be monitored.
- Missed and delayed medications were the most common medication incidents reported by the service. Changes in policy to promote improvements were ongoing. For example, the criteria for two nurses to check medication was widened to include all medication and intravenous antibiotic administration protocols had been changed so that all intravenous antibiotics were given through a medication pump. These interventions had improved control and monitoring during administration.
- A full time pharmacist trained in neonatal medicines was assigned to the unit and on-call advice was available out of hours.
- Local rules for prescribing antibiotics were in place to make sure these were used appropriately.

Records

- We reviewed ten sets of treatment records. These were readily available to staff. Nursing records were kept in a draw by each baby's cot and medical records were stored securely in a notes trolley kept in the clinical office.
- The nursing and medical notes were filed together in a single folder when the baby was discharged. The colour of the outer-folder differed for each year to make retrieval of birth records easier.
- The records reviewed were neat and the contents filed in a consistent order making information easier to find.
- Staff who provided treatment and care could be tracked because reports were legible, clearly signed and dated as required. A doctor's signature also included their General Medical Council (GMC) registration number.
- The trust promoted effective record keeping by allocating different record keeping tasks to staff. For example the administrator said one of her tasks was to make sure test results were filed correctly and always in the same place.

Neonatal services

- The neonatal unit was about to introduce an electronic record keeping system. Training had been planned for staff who would be 'super users'. Staff said they felt the system would be an improvement because uploading and accessing information would be quicker.

Safeguarding

- Records indicated that all medical staff, all band six and seven nurses and some band five nurses on the neonatal unit had completed the required level three safeguarding children training. Each shift had a band six or seven nurse on duty who provided specialist safeguarding advice.
- The trust's aim was for all nurses to complete this training. Records indicated this was discussed at a senior level and plans were in place to replace the level two safeguarding training on the unit's induction programme with level three training. This would make it mandatory for all new staff.
- Staff we spoke with were clear about what safeguarding concerns to report and how to report them. Staff were aware of the safeguarding children's lead for the unit and confident that systems were in place to highlight and protect babies, children and vulnerable adults from harm.
- A service wide safeguarding lead nurse was responsible for co-ordinating communication between the neonatal unit, labour suite, and post-natal ward or children services depending on the circumstances. We witnessed a detailed discussion about safeguarding issues for babies on the unit and staff reviewed care records to make sure these concerns were documented and easy to access.
- Reports in care records confirmed multi-agency teams were involved in dealing with safeguarding concerns. This was in keeping with the trust's safeguarding children's policy and best practice guidance.
- Entry to the neonatal unit was by security swipe card or intercom controlled from the clerk's desk, which was passed on the way to the cot spaces. Staff identified this as a risk because people who had been given entry to the unit sometimes then allowed entry to others. Some action had been taken to reduce the risk, for example raising awareness in the neonatal newsletter and put notices at the entrance of the unit.
- Staff in each bay ensured babies were observable and safely monitored at all times.

Mandatory training

- All staff received corporate and clinical mandatory training as a part of their initial induction, within two weeks of their start date. This was monitored by the clinical and nurse educators.
- There was also a mandatory training timetable to ensure staff repeated training to make sure they were up to date.
- Training involved classroom, face-to-face observation sessions, practical training and e-learning. Topics included the safe use of antibiotics, moving and handling, managing medication and risk management.
- The trust's records indicated that 90% of staff working at St Mary's hospital, which included the neonatal unit, were up to date with mandatory training. This was in line with the trust's mandatory training compliance target.
- New staff members described participating in a comprehensive mandatory training programme during their induction.
- We spoke with 14 members of staff each said they were up to date with mandatory training. This included yearly emergency life support training and neonatal life support if this was required.

Assessing and responding to patient risk

- Medical and nursing staff completed a full needs and risk assessment for all babies. Regular vital sign readings were recorded and reviewed. Monitors were set to alarm according to the needs of the individual baby. We saw that continual visual checks were recorded and to assist this, clear drapes were used so the baby's, colour, breaths and movements could be monitored.
- Tissue viability risk assessments were completed to ensure appropriate pressure care observations were made and pressure relieving care provided.
- The neonatal unit at St Mary's hospital provided a service for all neonatal medical and surgical conditions except for cardiac surgery. Escalation and transfer guidelines in place for these babies included contacting specialist neonatal cardiac surgery services within the northwest neonatal network and arranging transfer with the Greater Manchester neonatal transport team. These transfers were reported as an incident and one incident had been logged between 20 August 2014 and 19 August

Neonatal services

2015. We discussed the incident with senior staff and reviewed the investigation records, this evidence indicated that safety had been promoted because the trust's protocols and guidelines had been followed.

- There were emergency call bells by each cot. Consultants and the neonatal emergency response team were based on the unit.
- Parents told us emergencies were dealt with smoothly and calmly by staff and that even when a number of nurses and doctors were around, the atmosphere remained calm.

Nursing staffing

- The neonatal unit nurse staffing numbers and skill mix was based on the British Association of Perinatal Medicine (BAPM) best practice guidance. The BAPM guidance recommended 80% qualified nurses and 70% of these should have additional neonatal qualifications in specialism (QIS).
- Observations, records and information from staff indicated 90% of the nurses were qualified nurses and 70% of these had additional neonatal qualification in specialism (QIS) certificate. At times, this reduced to 60% due to staff turnover.
- The trust was taking steps to maintain the recommended 70% QIS trained nurses and aimed to have 80% QIS trained nurses.
- Babies received one nurse to one baby; one nurse to two babies and one nurse to four babies according to their level of need and there was always at least one QIS trained nurse in each bay.
- In addition, a band seven shift-coordinator who was not allocated patients was on duty to oversee the running of the unit.
- Six advanced neonatal nurse practitioners (ANNP) were also rostered to work on the unit to provide additional clinical support and complete specialist tasks such as intubation, taking bloods and other specialist procedures.
- The staffing report for the three months prior to the inspection showed there were enough nurses deployed to meet the needs of the babies on the unit.
- The number of nurses expected on duty was on display and this correlated with the numbers on the unit.
- Staff told us although there was pressure in relation to training and supporting an increased number of band five (junior) nurses there were always enough nurses of the correct skill-mix on duty.

- Staff on the neonatal unit had not recorded any staffing concerns or incidents between August 2014 and August 2015.

Medical staffing

- The service was funded for 15 consultants, eight middle-grade and 11 junior grade doctors. Locum doctors were employed when medical posts were not filled. Five of the 11 posts were filled by locum doctors. Advanced nurse practitioners who were qualified and competent to carry out some tasks of junior doctors were also used to support delivery of care.
- Consultant cover was provided through a consultant of the week system. There were four consultants on duty during the day, five days a week. At night, there was one consultant on site in the hospital and another on-call. There were two consultants available at weekends.
- Information provided by the trust identified that in May 2015 all consultants at St Mary's hospital, which included those working on the neonatal unit, were up to date with their appraisals.
- The neonatal medical and nursing team also provided outreach support to doctors and nurses looking after babies with specialist medical needs who were well enough to be looked after on the postnatal wards.

Major incident awareness and training

- Policies and procedures were in place for staff to follow in the event of major incidents such as flood, fire or power failures.
- A container stocked with evacuation cots, portable oxygen and other equipment was readily available.
- Major incident simulation training was completed by senior managers and band six and seven staff.
- Yearly major incident update training was provided to all other staff.

Are neonatal services effective?

Good



We have rated neonatal services as 'Good' for Effective because;

All care plans, procedures and guidelines used by doctors and nurses to plan care, including pain management, were

Neonatal services

up to date. These were based on best practice guidance from royal colleges and other respected research institutes. There was a comprehensive program of audits to check staff adherence to and the effectiveness of each process.

The unit was performing well in relation to the number of babies who received expressed breast milk from their mothers, and general outcomes for babies compared well with similar units in England.

Medical and nursing staff who worked directly with babies received training to maintain and improve their skills. Teams of specialist nurses with specific training such as long-term ventilation and bereavement counselling were also employed. Nurses and consultants were available on the unit seven days a week and consultant rounds were completed every day.

Evidence-based care and treatment

- The trust's neonatal care provision was based on best practice guidance and standards provided by relevant organisations such as the Royal College of Gynaecology and Obstetrics, National Institute for Clinical and Health Excellence (NICE), the Kings Fund and Royal College of Paediatric and Child Health (RCOPH).
- We reviewed ten policies, procedures and care pathways used on the unit. All identified national or international best practice guidance on which the policies were based. The dates on the policies indicated these were up-to-date and so provided the most recent guidance.
- The service used evidence based care pathways for monitoring and treating specific conditions for example, neonatal jaundice and caring for babies with Down's syndrome.
- The service had participated in a global research based programme called the 'Wee care project' which looked at neuroprotective development and family centred care and treatment by focusing on objectives such as maintaining a healing environment through the use of lowered light and noise levels and the promotion of skin to skin care. The post assessment report identified that St Mary's hospital had made great improvements in the levels of neuroprotective and developmental care provided and data showed higher scores than the average of all 'Wee Care' sites in every single core measure. Medical and nursing staff confirmed that practice was provided in keeping with evidence-based guidance.

- Records from governance meetings indicated there were robust and effective processes for reviewing established and introducing new policies and guidelines. Guidelines were monitored against the expected outcomes.
- The trust's audit plan for 2015 /2016 indicated that the service participated in a full program of national and local audits and a clinician had been identified to lead each project. Audit meetings took place monthly where compliance with best practice was discussed and action plans put in place.
- Documents providing information about updates also showed evidence of re-audit to check the effectiveness of planned interventions.
- Information in newsletters, on the neonatal unit intranet pages and discussion with staff indicated results and required changes were shared throughout the service.

Nutrition and hydration

- The service was performing well to ensure babies on the neonatal unit received breast milk. For example, mothers of babies who had been transferred from district general hospitals were successfully supported to express breast milk even though they had not commenced breast feeding when the baby was born or before transfer.
- Breast pumps were loaned to women. We saw that partners could borrow pumps for use by mothers who were not well enough to go to the unit.
- Mothers told us they received more support to breast feed when they visited the neonatal unit than on the postnatal wards.
- Breast milk was stored in an unlocked milk kitchen and the fridge was unlocked. This meant milk was accessible to anyone on the unit. Milk was originally stored in labelled tamper-proof bottles, however we observed that only small amounts were removed from each bottle for each feed and once the seal was broken the bottle was no longer tamperproof..

Pain relief

- Pain relief for babies on the neonatal unit had been included on the service for children and young people risk register since August 2014, and targets were detailed in the units 2015/16-2019/20 business plan. The processes for meeting the needs of neonatal babies in relation to assessing and treating pain was ongoing. A

Neonatal services

number of changes had been made and the trust had a milestone by which staff would be trained to ensure changes were embedded. The period for achieving this was between June and August 2016.

- Pain was measured using an assessment and management pain-scoring tool based on best practice pain management guidelines (Hodkinson et al 1994). The assessment included charting the baby's demeanour and responses to touch and intervention was provided according to the score.
- The service actively networked with world authorities and leading experts in neonatal care in order to identify innovative processes to reduce pain and discomfort. Local audits to check the effectiveness of current best practice was also undertaken. For example at the time of the inspection, the neonatal unit was involved in the global review of the use of sucrose in contrast to a feed as analgesia during minor procedures.
- The trust requested feedback from parents about the pain control offered to their babies. 10% voiced a level of dissatisfaction. Analysis of this result indicated that staff did not explain what pain reduction measures were being taken and so the service was working with staff to improve communication in this area.

Patient outcomes

- The neonatal guidelines and care pathways were on the staff intranet site. There was a computer at each cot space and so staff had access to these, as well as safety alert and other information. We saw that access was quick and easy.
- The trust had a record of accomplishment of participating in the National Neonatal Audit Program (NNAP). NNAP audits clinical practice for all participating neonatal services against national standards. Results in the recent 2014 NNAP summary report (due for publication late 2015) showed this service performed better than the England average in most areas audited and had achieved significant improvements in some standards since the previous 2013 audit.
- The service was now better than the England average for completing eye checks in line with national guidance for babies born with a very low birth weight or before 32 weeks gestation. This had been achieved through introducing specialist equipment and training a qualified nurse to work alongside the consultant ophthalmologist.

- The service now above the recommended standard for the number of babies receiving breast milk on discharge from the unit; this was 69% which was an increase from 54% in 2013. The 2014 England average was 60%.
- Although still below average, a significant improvement had been achieved in the percentage of mothers seen by a consultant neonatologist within 24 hours of their baby being admitted to the unit. The service now achieved 82% compliance, an increase from 62% in 2013. The 2014 England average was 87%.
- The standard related to the percentage of women who received antenatal steroid treatment had not improved and remained worse than the England average. We saw that the neonatal service was working closely with the maternity services to improve performance in this area.
- Local audits completed by the neonatal service drove improvements in other departments such as midwifery. For example, the admission audits showed a trend for admissions from the postnatal unit due to hyperglycaemia; respiratory problems and hypothermia. In response to the review, an action plan initiated an outreach service from neonates into the postnatal wards providing advice and guidance to midwives and doctors.
- We saw that changes, initiated by audits, were shared with staff through different forums and the result were displayed on the unit's notice board for staff and parents to see.

Competent staff

- The neonatal service employed clinical educators who led an educational support team who oversaw a number of research and education work-streams.
- All staff rotated between intensive care, high dependency and special care bays to ensure competencies were maintained and developed.
- New staff and newly qualified staff wore specific lanyards so it was recognised that they needed additional support and protected against them being asked to work outside of their competency.
- When working with intensive care cots new staff were initially supernumerary so they could work closely and learn from established staff.
- In addition to competency training, when in use new equipment was also made available for staff to manipulate, become familiar with and comment on before it was fully introduced.

Neonatal services

- The 2015/2016 training needs analysis for the unit indicated staff were supported to complete post-qualifying learning to maintain and develop their competencies. Courses on offer included examination of the newborn, and tissue viability.

Multidisciplinary working

- The service worked well with district general hospitals in relation to receiving babies into the neonatal unit and transferring babies out. There was evidence of multidisciplinary team working between the neonatal services, internal departments and external service providers to ensure effective care.
- There were regular meetings, which indicated effective lines of communication between senior managers for the neonatal and maternity services. This resulted in the services identifying risks to providing a safe and seamless service to women and babies. Effective steps were taken, such as the development of specialist teams, to ensure neonatal care was provided as quickly as possible for as long as required.
- The service had a clear protocol for working with the fetal medicine and fetal screening services to ensure they were prepared to receive babies with known congenital anomalies as planned.
- The discharge process included working with the postnatal midwives to support mothers and their babies. A community team worked jointly with community paediatric nurses.
- For babies with complex health needs, multidisciplinary working was managed by neonatal specialist pathway coordinators so that the baby's care was transferred smoothly over to local paediatric services or services in the baby's area of origin.
- The service had a service level agreement and well-rehearsed protocols with the neonatal transfer service for babies who require transport.
- The unit had access to physiotherapists 16 hours a week and speech and language therapists (SALT) six hours a week for swallowing and feeding assessment and support. Other therapy was provided on a referral basis depending on the need of the baby.

Seven-day services

- All the services required to provide care and support to babies on the neonatal unit were available 24 hours a day, seven days a week.

- The trust's service level agreement meant the neonatal transfer service was available at all times.
- Access to imaging and diagnostics services was available at all times.
- A neonatal consultant was on site at all times and an additional one was on-call if required.

Access to information

- Doctors, nurses and allied health professionals had immediate access to patient records in order for them to deliver effective care and treatment.
- There was a team of administrators to deal with discharge letters using an electronic discharge system and ensure discharge letters were sent out promptly.
- Babies' records were aligned with their mothers which supported staff in making decisions based on up to date information.
- There were enough computers available to allow staff to have quick access to trust policies, guidance and the staff rostering systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Care records confirmed parents gave written consent to care and treatment for their baby as appropriate. Systems were in place to ensure that only carers authorised to give consent did so.
- Parents described the process of giving consent. This included receiving detailed information from doctors and nurses in a way that could be understood so an informed decision was made.
- Parents also confirmed that staff explained what they were going to do and asked verbal consent whenever they were present. Staff also described care that had been provided in their absence.

Are neonatal services caring?

Good



We have rated neonatal services as 'Good' for Caring because;

Staff demonstrated a caring and compassionate attitude towards babies, parents and the extended family and enabled parents to be as involved in their baby's care as possible. Parents felt they were involved in decisions about the care of their baby.

Neonatal services

The neonatal unit used video technology to support women who were not well enough to visit their baby, and a bleep system for parents so that they were involved when decisions were being made by medical teams. Specialist support was provided so that emotional support and practical advice was available for parents. The specialist neonatal bereavement support team were committed to providing compassionate care and emotional support to families. Initiatives developed by the service had been recognised as good practice.

Compassionate care

- All staff were respectful and caring when looking after babies in their care. Babies were covered and their dignity was preserved through all procedures.
- Interventions and personal care such as cleansing and checking equipment was completed in one go to reduce the number of times babies were handled and disturbed.
- The service participated in 'Baby Friendly' and 'Best Beginnings' initiatives to promote a nurturing caring environment for babies on the neonatal unit.

Understanding and involvement of patients and those close to them

- The neonatal service used video technology so that women who were not well enough to visit the neonatal unit could see their baby visually. This meant contact was made and bonding could start as quickly as possible.
- There was a family support team to help parents develop a relationship with their babies and promote child development. This team had compiled a library of children's books to encourage parents to begin reading to their baby as soon as possible.
- Parents were given a bleep so they could be alerted to attend the unit when their baby was being seen by medical teams. This also meant confidentiality was maintained because only the parents of the baby been discussed was present.
- A presentation of a patient's story for reflection was a standing item on the agenda of the neonatal clinical effectiveness meetings.

Emotional support

- The family support team lead described their role as being available for parents. The role included supporting parent with planning visiting and spending

time in the hospital, familiarising them to hospital routines, making sure parents were as comfortable as possible with regards to meals and drink, signposting to support groups as required and supporting parents through bad news.

- Parents told us the staff on the unit were caring and provided emotional support and encouragement.
- Parents said they felt comfortable and confident about leaving their baby in the care of the nurses and doctors on the unit.

End of life care

- There was a specialist neonatal bereavement support team situated in the unit who cared for parents when their baby died. Processes were in place to allow the parents to spend as time as they needed with their baby if the death occurred on the unit.
- The unit admits around 1000 infants annually of which there were 40-50 deaths.
- We met with four members from the bereavement team and looked at resources related to bereavement such as sibling support books, information leaflets for bereaved parents and cultural/spiritual resources.
- The facilities met the needs of grieving parents and their families. There was a dedicated newly refurbished suite for parents to use to spend time with their babies. The room was fully equipped and decorated to provide a homely environment. Parents were able to have private time to be with their child whilst still having access to discreet support by staff through a call system within the neonatal unit.
- There were policies and procedures in place to support care provision, which were in line with national guidance including bereavement care and post-natal support.
- Staff from the service attended the Greater Manchester Neonatal Network palliative care group to work with other partners to devise and share best practice policies, and guidelines to support end of life care. The service was externally facing and proactive in aiming to provide evidence based high quality service.
- Each death was reviewed by a consultant not involved in the care of the baby. Neonatal deaths were reported through the neonatal mortality portal and externally reviewed by the northwest neonatal clinical effectiveness group.

Neonatal services

- The bereavement team supported the education of student nursing and medical staff in end of life care and bereavement.
- Feedback from parents said that they appreciated having keepsakes of their baby. Staff gave out a memory box to collect keepsakes such as the baby cot card, name bands and cot sheets. Staff offered to take prints and/or cast of a baby's hands and feet and a lock of hair with the consent of parents.
- An annual memorial service was held by St Mary's hospital and staff from the neonatal service were involved in planning these services.
- The service also had a book of remembrance on the neonatal unit for parents to write thoughts about their babies as well as poems written by other families.
- Staff held coffee mornings during the year for parent's and supported them with future pregnancies.
- Whilst on the unit we also met a member of the chaplaincy service who had regular contact with the service to support the spiritual and emotional needs parents, families and staff. They described the care of grieving parents as exemplary and compassionate.
- Translators were available for people whose English was not their first language.
- The bereavement service had a formal process for feedback from parents and families. This was carried out through the "family satisfaction audit". They also received informal feedback from families when visited at home by the bereavement team.
- The service engaged with the other professionals and for example hosted a regional open day. This involved other health professionals visit the unit and sharing good practice in relation to bereavement care.
- The bereavement team had won external recognition as winners of a national award for "best hospital bereavement service" and "medical professional".

Are neonatal services responsive?

Good



We have rated neonatal services as 'Good' for Responsive because;

The service was proactive in participating in research projects to identify areas for improvement and support service planning to meet the needs of local people.

Processes were in place to ensure babies could access the specialist neonatal service when required and the needs of parents were accommodated. The service actively sought the opinion of parents and acted on their ideas. This meant services provided were planned to meet the needs of local people.

Service planning and delivery to meet the needs of local people

- The service was proactive in responding to international research results indicating the potential impact detrimental effect on the development of babies who spent time on neonatal unit. In response, the service was part of the national WEE care programme and was the first to trial the programme in the UK. The Wee Care NICU program promoted a developmentally supportive care environment on neonatal units. The process included providing a low noise and light levels and using specific techniques and processes to strengthen parental bonding with babies.
- The process included a comprehensive baseline review of the neonatal unit by an independent health research organisation. Detailed action plans and review dates had been developed to achieve the changes needed to implement the program.
- Changes introduced in response to the review including dedicated quiet time, support for mothers and babies to have skin-to-skin contact; low lighting and noise reduction initiatives. Positioning of babies was also reviewed.
- In 2012 staff from the neonatal service and the Manchester Royal Eye Hospital developed a new model of care in which a trained retinopathy of prematurity (RoP) screening nurse undertakes on-site retinal screens using a mobile device (Retcam). The images produced are graded and sent electronically to the ophthalmologist for confirmation. A recent audit of this process demonstrated that the screening nurse produced high quality gradable images of the neonatal retina in 100% of cases. The North West Neonatal Operational Network has asked the trust to replicate this model across the whole conurbation using a peripartetic service. The aim is to prevent infants from being transferred to a specialist centre unnecessarily and to ensure that examinations are undertaken in a safe and timely manner.

Access and flow

Neonatal services

- In order to manage the access and flow of patients, shift co-ordinators liaised with members of the northwest neonatal network three times a day. This was to check cot availability and the potential demand for the service on a regional basis. This process meant the service could assess whether the unit could safely accept additional babies and use the escalation policy if required.
- The cot spaces on the neonatal unit could be reconfigured to increase the number of intensive care cots by reducing special care cots if required. The intensive care cot occupancy rate was 95% in June 2015 and the average occupancy for the unit was 85%. NHS England recommends that 70% is the safest maximum occupancy for neonatal units.
- Senior managers explained that at times babies were being looked after by their mothers in the 'step-down' rooms which meant the empty cot could be used.
- The service had put forward a business case for additional cot spaces. This proposal was under discussion with health commissioners at the time of our inspection.

Meeting people's individual needs

- There were five parent rooms on the unit and family-centred accommodation where siblings could also stay was provided in serviced flats situated in the grounds of the hospital.
- Discussion with senior managers, a chaplain and parents indicated that the needs of the whole family were considered by the service.
- Day facilities were available so that non-resident families and other visitors could be comfortable while spending time on the unit.
- In 2014, the service introduced the use of video telephony in order to enable newly delivered or sick women unable to visit the Newborn Intensive Care Unit, to see and hear their babies. This innovative approach to promoting and strengthening the early bonding experience was made possible through the use of software applications which enable a video call to be made over Wi-Fi using a pair of dedicated tablet devices. The technology allowed the mother to see her baby in real time and the opportunity for the NICU nurse to explain what all the devices and lines connected to the baby were for and to answer any questions about the baby's care and wellbeing.

Learning from complaints and concerns

- There were few complaints received about the neonatal service however, the trust encouraged parents to complete a satisfaction survey and provide feedback about experiences when their baby was discharged.
- We found that the service responded to information received, for example as a result of feedback small storage lockers had been provided in sufficient numbers for one to be allocated to each cot. These were housed in the main entrance of the unit.

Are neonatal services well-led?

Good



We have rated neonatal services as 'Good' for Well-led because;

There was a clear strategy for the service that was understood by all staff we spoke with. The managers were proactive in finding ways to improve the service and inspired creativity in their staff.

The outcomes of a comprehensive programme of local audits demonstrated the service was successful in delivering care in keeping with the trust's policies and expectations. Action was taken if there were shortfalls. There were processes in place to monitor the delivery of quality of care. The neonatal unit had achieved "gold accreditation" as part of the trusts assessment of quality assurance.

There was an open culture and staff, parents and other stakeholders felt listened to and valued.

Vision and strategy for this service

- The neonatal intensive care service managers had developed a business plan 2015/16 to 2019/20. This detailed short, medium and long-term goals and strategies relating to medical and nursing staff, the size and focus of the service and future changes in commissioning opportunities.
- Our review of governance board meetings indicated these plans were effectively monitored and reviewed appropriately. The strategy also included an audit of how well plans progressed and evolved.

Neonatal services

- The St Mary's hospital annual report 2014/2015 identified future initiatives and detailed the progress made in achieving previous plans, such as increasing research activity and recruiting additional nurses.
- Nursing staff readily discussed the trust's vision in relation to becoming a centre of research excellence and said the deputy chief executive visited the unit regularly.

Governance, risk management and quality measurement

- The trust completed an annual accreditation process for all units, wards and services. The process looked at the quality of clinical practice, interactions with patients and families, and nursing practice. The awards were gold (the best), silver (satisfactory) or bronze (requiring some additional support) accreditation. The neonatal service had been awarded gold accreditation.
- Neonatal services were reported to the hospital board and there were robust governance arrangements in place including quality measurements. For example, the success of the neonatal outreach service was acknowledged in the Central Manchester University Hospitals NHS Foundation Trust annual report 2014/2015.
- The members of trust's governance board completed a quality assurance visit at St Mary's hospital, which included the neonatal unit in September 2015. This was led by the corporate director. The notes from the meeting called 'Mini Quality Review September 2015' indicated that board members identified and commented on good practice and areas for improvement. This meant responsibility for the quality and safety of the neonatal service was taken at a senior level.
- This report however did not confirm which non-executive board members had completed the visit. It was unclear whether visitors or staff had been able to give an opinion about the neonatal unit.
- The services for children and young people risk register included risks for the neonatal service. The risks included hypothetical risks with regards to equipment and also risks concerned with practice for example the risk of inconsistent use of the pain assessment tool on neonates. We saw that risks had been reviewed, staff responsible for managing the risks were identified, a plan of action was evident and appropriate future dates to review the risks had been planned.

Leadership of service

- Staff stated that the leadership of the unit was very visible and the clinical director, directorate manager and lead nurse were approachable and motivating.
- The evidence gathered throughout the inspection and the quality of information provided for the public in the St Mary's Hospital 2014/2015 annual report indicated that managers understood the challenges to good quality care and were able to identify the actions needed to address them.
- Discussion with key managers indicated they had detailed knowledge about the day-to-day running of the service. They also had the ability and authority to drive forward change and improvements as required.
- The service had developed a robust succession plan for use in the event of managerial change.

Culture within the service

- Staff described a culture, which supported effective teamwork and promoted cooperation with other hospital services and partner agencies.
- The culture was also nurturing and gave staff the confidence to question their practice so that improvements could be made.
- Research nurses said they wanted to achieve a 'world class' standard of care. Staff felt supported to achieve this through time and encouragement to identify, initiate and complete studies and network with centres of excellence nationally and internationally. They also assessed that the experience of caring for babies with complex needs, their close partnership working with the medical team and the open and questioning culture promoted excellence.
- Unit staff felt supported to identify new research and audit ideas to improve the experience and outcomes for babies and families.

Public engagement

- There was an active parent's forum who had been involved in developing the facilities and environment of the neonatal unit. They had been consulted about the decor of the unit. Their involvement meant the environment was designed with a focus on the emotional needs of visitors. This was achieved through making careful choices about the images and words used throughout the unit.

Neonatal services

- The information wall on the unit was designed by the parent's forum and reflected true experiences aimed to help families.
- There were a team of volunteers working on the unit support parents and staff on the unit took part in public fundraising events for the unit.
- Feedback indicated that 99% of parents felt involved in planning care for their baby.
- The service encouraged parents to complete a questionnaire when their baby left the unit.
- Staff and parents had ready access to a language interpretation service.

Staff engagement

- Medical and nursing staff were clear about their involvement and role in relation to the service delivery.
- The middle management structure was easy to understand and interviews with all staff demonstrated they had a clear understanding of each other's roles and responsibilities.
- In the 2014 St Mary's hospital staff survey, which included newborn services, 69% of staff who responded felt able to contribute towards improvements at work. This was slightly better than the England average of 68%.







Innovation, improvement and sustainability

- The service was proficient at developing local innovation, networking and researching new ways of working and there were no limits on where ideas could originate. Processes included literature searches, developing individual interests in topics, response to local audits and reviewing activities and practice to ensure they were research based.
- In 2014, the use of video telephony was introduced in order to enable newly delivered or sick women unable to visit the Newborn Intensive Care Unit, to see and hear their babies. This innovative approach to promoting and strengthening the early bonding experience was made

possible through the use of software applications which enable a video call to be made over Wi-Fi using a pair of dedicated tablet devices. The technology allowed the mother to see her baby in real time and the opportunity for the NICU nurse to explain what all the devices and lines connected to the baby were for and to answer any questions about the baby's care and wellbeing.

- There were robust systems in place for ensuring infrastructures such as specialist staff, equipment and other processes were place to ensure approved innovation was sustainable.
- The doctors and nurses on the neonatal unit worked closely with other members of the north-west operational delivery network. Together they worked as the North West operations network.
- The neonatal service published information with other members of the network on the Northwest neonatal network operations delivery website. Guidelines and protocols used between units were similar and information provided to parents and relatives was the same from each unit. This indicated the service was proactive in working effectively with other neonatal services.
- In 2012 staff from the neonatal service and the Manchester Royal Eye Hospital developed a new model of care in which a trained retinopathy of prematurity (RoP) screening nurse undertakes on-site retinal screens using a mobile device (Retcam). The images produced are graded and sent electronically to the ophthalmologist for confirmation. A recent audit of this process demonstrated that the screening nurse produced high quality gradable images of the neonatal retina in 100% of cases. The North West Neonatal Operational Network has asked the trust to replicate this model across the whole conurbation using a peripatetic service. The aim is to prevent infants from being transferred to a specialist centre unnecessarily and to ensure that examinations are undertaken in a safe and timely manner.

Services for children and young people

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

Information about the service

Royal Manchester Children's Hospital (RMCH) is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the trust's main site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a children's hospital. RMCH provides specialist healthcare services for children and young people throughout the North West, as well as nationally and internationally. With 371 beds it is the largest single-site children's hospital in the UK.

The hospital provides a range of medical services, including: gastroenterology, burns, long-term ventilation and neuro rehabilitation, haematology and oncology, cardiology, respiratory, rheumatology, immunology, endocrine, diabetes and metabolic disorders. Hospital episode statistics (HES) data for 2014 showed there were 19,130 hospital admissions to the medical wards at RMCH between 1 November 2014 and 31 October 2015. RMCH also provides paediatric outpatient and diagnostic services. For the period January to December 2014, the hospital had 136,304 outpatient attendances. The service offers a combination of consultant and nurse-led clinics across a range of specialities including: general paediatrics, diabetes, cardiology, immunology and allergy, ear, nose and throat (ENT), fracture clinic and therapy services.

Diagnostic and interventional radiography services are also provided which include: general x-ray, computerised tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound and nuclear medicine. The laboratory services provide diagnostic testing to enhance and support patient diagnosis and treatment.

RMCH is the main site for children's surgery, although some children's surgery is also carried out at Trafford General Hospital. RMCH is the largest provider of children's surgery in the UK. Services provided include: general paediatric surgery, urology, nephrology, ENT, cleft lip and palate and dentistry, orthopaedics, spinal surgery, burns and plastics, neurosciences and a burns unit.

Transition services for young people are managed by individual specialities within the hospital and are not managed as a distinct clinical area (such as medicine or surgery). 'Transition' describes the process of planning, preparing and moving a young person from children's services to adult services. The hospital provides both inpatient and outpatient services for young people over the age of 11 years and up to the age of 19 years. There are outpatient services and a children's community nursing team, enabling young people to attend appointments as outpatients, or arrange an appointment to be seen at home. Areas of expertise include: chronic disease specialists (epilepsy, asthma, diabetes, cystic fibrosis), continence team, palliative care team and home ventilation/continuing care team. RMCH has its own on-site school that employs 44 members of staff, including teachers, teaching assistants and administrators, who work throughout all sites. The hospital school which follows the national curriculum educates children and young people aged between three and 19 years old.

Critical care is delivered at RMCH in two distinct clinical areas. There is the paediatric intensive care unit (PICU) commissioned to provide care and treatment to 17 children (level 2). It provides continuous nursing supervision for children and babies who usually require respiratory

Services for children and young people

support. It is one of the leading centres in the North West and the largest general PICU in the UK. There is also a 12 bedded paediatric high dependency unit (PHDU), which provides specialist care for children requiring more observation, intervention or monitoring than can be safely provided on the general wards; it acts as a 'step up' from the wards and a 'step down' from PICU. Children and young people with end of life and palliative care needs are nursed on the wards in RMCH. There is no overarching children's specialist palliative care team for the hospital.

Management of end of life care is on a case by case basis involving clinicians from the relevant speciality teams, children, young people and their parents. RMCH has a bereavement team who provide care and support to relatives following the death of their child. There were 55 deaths in the children's hospital in 2014/15.

We carried out an announced inspection at RMCH on 4 and 5 November 2015 and an unannounced inspection on 26 November 2015.

As part of our inspection we visited the PICU and PHDU; theatres, anaesthetics and surgical wards 76, 77 and 78; medical wards: ward 75 (secondary paediatrics, gastroenterology), ward 84 (haematology, oncology), the bone marrow transplant unit, ward 85 (cardiology, respiratory, rheumatology, immunology, endocrine, diabetes, metabolic) and ward 83 (long term ventilation and neuro-rehabilitation) and a range of outpatient services including: cardiology, endocrinology, fracture clinic, physiotherapy and radiology. We also inspected the end of life care at RMCH as part of our announced inspection. We visited seven wards where end of life care could be provided, the chapel/multi-faith room, the hospital mortuary, viewing room and bereavement services. As part of our inspection of transition services we visited six inpatient areas; including two services within Manchester Royal Infirmary,

We spoke with more than 100 members of staff including: nurses, student nurses, doctors, consultants, locum doctors, clinical fellows, junior doctors, ward managers, the clinical effectiveness lead, matrons, health care assistants, physiotherapists, play therapists, anatomical pathology technicians, members of the senior management team, occupational therapists, ward clerks and housekeepers. We

also spoke with members of the trust-wide adult hospital specialist palliative care team, including the adult and paediatric clinical leads for palliative care to understand their input to RMCH end of life care.

We spoke with 54 patients, relatives and carers. We observed care and treatment and reviewed 69 sets of records. We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust.

Services for children and young people

Summary of findings

We have rated children and young people's services as 'Good' overall because;

Incidents were reported appropriately using an electronic reporting system. Staff were aware of the system and how to use it. There were examples of learning from incidents and how this learning was shared across the service and trust wide. Cleanliness and hygiene was of a high standard in the areas we visited and the majority of staff followed good practice guidance in relation to the control and prevention of infection. However, improvements were required in relation to the monitoring of medicine fridge temperatures and resuscitation equipment.

Patients received care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were completed and subsequent action plans implemented. Children and young people's services were delivered by caring, committed and compassionate staff that treated people with dignity and respect. Staff actively involved young people and their parents and carers in all aspects of their care. Policies and procedures were in place to identify and refer cases of suspected abuse and staff knew the type of concerns they should escalate. However, the processes to highlight previous or ongoing safeguarding or child protection concerns were not robust.

Services were planned and delivered in a way that met the needs of the local population. There were facilities to enable parents to be with their child at all times. We observed that each ward provided a child friendly environment. Interpreting services were available as required. However, improvements were required in relation to referral to treatment times in outpatient services. Long wait times for elective treatment at RMCH remained a challenge with a number of specialities failing to meet the 18 week referral to treatment target.

The hospital had recently undergone an organisational restructure and had moved to having clinical service units. The clinical leads described a very clear vision for their departments. At the time of the inspection, we

found this was not yet embedded in practice. There was a robust governance structure in place within the children's division which fed into the trust risk management committee. Monthly governance meetings were held and attended by key professionals. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board. Risk registers were in place and well maintained, although we found that some risks identified by managers were not on the risk register.

There was strong clinical and managerial leadership at unit and divisional level. However, the model of care in the PHDU meant that at certain times (out of hours) overall responsibility for the patient's care and treatment was with the parent team and not the intensive care consultant. This represented a risk to timely and consistent decision making. Whilst some progress had been made to meet national guidance following the removal of the Liverpool care pathway in 2014 we found a lack of clarity about what documentation was in place for end of life care at RMCH. There was no clear strategy for end of life care throughout children's services. Similarly, there was no clear policy or strategy in place for transition services.

Services for children and young people

Are services for children and young people safe?

Good



We have rated services for children and young people as 'Good' for Safe. However some improvements were required to ensure equipment is appropriately checked and systems to ensure safeguarding concerns are shared across the hospital and community are robust.

Incidents were reported using an electronic reporting system. Staff were knowledgeable about what types of incident they needed to report and could demonstrate how these would be recorded and escalated. Medicines, including controlled drugs, were stored securely and access was limited to qualified staff. The prescription and administration of medication was done in accordance with trust policy. However, in some services, we found occasions where controlled drugs and fridge temperatures had not been checked as per trust policy. The wards and clinical areas we visited were visibly clean and tidy. The majority of staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. There were sufficient numbers of suitably skilled nursing and medical staff to care for patients in most areas. Systems were in place to ensure a fair, needs-led distribution of staff.

The majority of records we reviewed as part of our announced inspection were completed to a good standard. However, they did not always accurately reflect identified safeguarding concerns. On our unannounced inspection we found improvements had been made and more recent episodes of care had clear safeguarding concerns identified. The processes to highlight previous or ongoing safeguarding or child protection concerns were not robust to ensure they were shared across the hospital and community. Community health professionals such as health visitors and school nurses were not informed of a child's hospital admission or care plan.

Emergency resuscitation equipment was in place on all the wards visited, but records showed that, in some areas, it had not been checked daily in line with trust policy. There

was minimal access to specialist palliative medical support either in hours or out of hours (overnight or at weekends) other than two sessions from a community paediatrician with a special interest in palliative care.

Incidents

- Incidents were reported using an electronic reporting system. Staff were knowledgeable about what type of incident they needed to report and could demonstrate how these would be recorded and escalated.
- There had been five serious incidents within children's services requiring investigation between 1 August 2014 and 31 July 2015. All serious incidents were investigated using a root cause analysis (RCA) approach. As a result of the investigation, action plans were developed and monitored for completion. An RCA is a systematic investigation of adverse incidents, which can identify system failures and areas for improvement.
- We reviewed the investigation reports for two serious incidents, one involved a manual handling issue during a surgical procedure and the other involved the mislabelling of a blood product. In both instances, staff were able to demonstrate how clinical practice had changed following the investigations, and that these changes were embedded into practice.
- Within medical services there were 68 incidents reported between 1 June 2014 and 31 August 2015 of which 62 were reported as low or minor harm. Communication problems were the highest type of incident reported (15 in total).
- Incident data for 20 August 2014 to 19 August 2015 showed that 686 incidents were reported across paediatric intensive care unit (PICU) (457) and paediatric high dependency unit (PHDU) (229). 609 of the reported incidents were judged as being near misses where there was no harm to the patient. This reflects a positive culture where reporting is encouraged whether there is patient harm or not.
- Data from the trust indicated there were five radiation incidents relating to RMCH in the period December 2014 to October 2015. Radiation incident report details were sent to the director of clinical governance who forwarded information to the chief executive as required by regulations.
- Trends were mapped with lessons learned and actions fed back to staff verbally, by email and via a monthly newsletter.

Services for children and young people

- There was no process in place to monitor incidents that specifically related to transition or end of life services. As a result, there was no hospital-wide overview of transition or end of life service specific incidents. It was therefore unclear how lessons learnt would be identified and shared with staff across the hospital or in adult services.
- Staff across children and young people's services were familiar with the term 'Duty of Candour' and patients and relatives had been informed of incidents which had involved them. 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.
- Monthly mortality review meetings took place and these were attended by a range of clinicians. All child deaths were reviewed at these meetings and investigated by a consultant who had not been involved in the child's care. The minutes of the meetings included action points and highlighted learning opportunities.
- The results from the trust wide May 2015 hand hygiene audit showed that PICU was 92% compliant with hand hygiene protocols amongst nurses, allied health professionals and medical staff and 100% compliant in PHDU.
- 'I am clean' stickers were placed on equipment when it had been cleaned, including notes trolleys, medication trolleys, computer stations and clinical equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. However, in medical care services, we saw five sharps bins on wards 75, 84 and 85 that had not been dated when opened and the clinical area where the sharps bin was used had not been identified. This was not in line with the trust's policy.
- There had been no cases of either methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile in the children's hospital between 1 June 2014 and 1 June 2015. All patients who had been in hospital within the previous six months were screened for MRSA on admission to hospital.
- Sterile services were based on site and a well-organised system was in place to allow the rapid access to sterile instruments. Of particular note was the unit's response to the risk of variant Creutzfeldt-Jakob disease (vCJD) cross contamination, during high-risk surgical procedures such as spinal surgery and neurosurgery. In order to minimise the risk of contamination with vCJD, the unit segregated high risk surgical cases and then segregated these cases further, by identifying high-risk children that were born pre and post 1997. The matron explained that the reason for this extra caution was because there is no clear cut-off date for when vCJD appeared in the general population prior to 1997.
- A number of patients on one ward had the infection; carbapenemase producing enterobacteriaceae (CPE). These patients were isolated in side rooms which had en-suite facilities. A notice of infection was placed, in a prominent position, on the door, outside of the room to warn people before entering.
- Several children were being isolated on ward 75 in the children's hospital during the inspection as an infection prevention measure. We observed that two of these children did not have en-suite facilities and were using ward bathroom facilities. One of these children had to use a toilet which was across the corridor from their room and there was no sign on the toilet door to

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was submitted from the hospital and reported at divisional level via a clinical safety dashboard.
- The safety thermometer dashboard provided by the trust included data for all of the children's hospital and was not segregated by service. The data showed there were three level 2 falls between March and May 2015 and 27 pressure ulcers between July 2014 and July 2015.
- Safety thermometer reports were displayed on the wards or outside the units so performance could be monitored.

Cleanliness, infection control and hygiene

- The wards and clinical areas we visited were visibly clean and tidy. The majority of staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy.
- Hand washing facilities, including hand gel, were readily available in prominent positions on entry to each clinical area. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons whilst delivering care.

Services for children and young people

prevent other people from using it. The second child was using a bathroom which was located at the other end of the ward. This meant there was a risk of the spread of infection.

- On all the medical wards in the children's hospital, there were curtains between the cubicles. There was no label on the curtains to identify when they were last cleaned or when the next scheduled clean would be. Staff, including the ward manager, were unaware of any cleaning schedule that was in place for them.
- We observed a number of drawers containing documents on ward 84 in the children's hospital and the bone marrow transplant unit that expelled a significant and visible amount of dust when opened. The nurse in charge told us this was because the care plans were rarely used. We looked at this again during our unannounced inspection and found that the situation had not been resolved.

Environment and equipment

- The wards we visited in the children's hospital were generally well maintained, with controlled access and provided a suitable environment for treating children.
- Emergency resuscitation equipment was in place in the children's hospital but records indicated that it had not been checked daily in all areas, as per trust policy.
- The resuscitation trolley on PICU had gaps (four days) where records indicated it had not been checked. On PHDU, the resuscitation trolleys were both dirty and had out of date protocols in place. This was brought to the attention of the nurse in charge and action was promptly taken to resolve the issues.
- In surgical services, checks of resuscitation equipment complied with the trust policy in the majority of instances. However, between September and November 2015, there were two instances, on one ward and five instances on another, where the logbook was not signed to indicate that staff had checked the trolley. Four resuscitation trollies were inspected, including one in theatres. Three of the trollies were visibly clean and contained the required equipment. However, one trolley was found to be dirty, lacking a piece of essential equipment and had an open dose of heparin (anticoagulant medication) lying on top of the trolley. This was raised with staff at the time of inspection and the errors were rectified. On the unannounced inspection, we found that a bag valve mask and suction equipment was not sealed on two separate trollies, which contravened the trust's policy.
- There was a pod system in place in the children's hospital for the quick transfer of specimens to the pathology laboratory. The pod system on ward 85 was not used to send bloods for blood gases (due to the type of tubes used) and the laboratory was a significant distance from the ward. One mother told us that blood gases were taken from her baby seven times in one night because the blood clotted before it arrived at the laboratory, which made it unsuitable for testing.
- The majority of electronic equipment we checked in the children's hospital had been tested for electrical safety. However, we observed some equipment in medical care services, such as a blood pressure machine (expired October 2011) and baby weighing scales (expired 2014) that was not in date with portable appliance testing (PAT). In addition, we observed a waist-high box full of used batteries on ward 85 that was behind the nurses' station, accessible to young children.
- We saw evidence that equipment such as weighing scales had been checked and calibrated but this was not consistent across the outpatients department. For example, in the height and weight room in clinic 5, we found scales that had no information to show when they were last calibrated and a blood pressure machine that had a sticker showing it should have been checked in March 2015 but it was unclear if this had been completed.
- In surgical services, there were a number of anaesthetic devices that were on loan from private companies. There was no reliable system in the department to indicate which equipment was on loan nor how this equipment was serviced. In addition, there was no protocol to record whether staff were trained in the use of loaned equipment.
- The radiology department had one computerised tomography (CT) scanner, one magnetic resonance imaging (MRI) scanner and one gamma camera. 'Local rules' were observed in the department to support the safe use of the equipment. There was evidence of regular quality assurance and maintenance of radiology equipment.
- Clear signage and safety warning lights were in place in radiology to warn people about potential radiation exposure.

Services for children and young people

- Paediatric mortuary services were licensed by the Human Tissue Authority (HTA). HTA certification was visible in the mortuary. The HTA licenses and inspects organisations that remove, store and use tissue for medical treatment, post-mortem examination and teaching.
- There was a syringe pump monitoring checklist in place which included four hourly safety prompts and checks of the needle site, battery and volume of infusion remaining in the syringe. The use of syringe drivers had been supported by regular and ongoing staff training. However, this was not mandatory and was dependent on wards being able to release staff.

Medicines

- Medicines, including controlled drugs, and medical gases were stored securely and access was limited to qualified staff employed by the trust. The keys for the controlled drugs were kept separately for increased security.
- Registers for controlled drugs were maintained. However, in medical care services, records indicated there were seven days in October 2015 where the controlled drugs had not been checked. Trust protocol was for staff to check controlled drugs at least once in every 24 hour period. In addition, we found six examples of expired medicines (ward 84 and 85) some of which were controlled drugs.
- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Temperatures were supposed to be checked and recorded daily. However, on ward 84, the fridge temperature had not been checked on six days in the month prior to the inspection. On wards 75 and 84, the temperature had been recorded as being outside the recommended temperature range on 15 occasions in the three months prior to the inspection but there was no evidence of any action taken. This was against the trust's policy. Any change in temperature out of the recommended range could potentially make medication in the fridge unfit for use.
- In surgical services, not all drug fridges displayed a thermometer. The department housekeeper held the responsibility for monitoring fridge temperatures but the lack of a displayed thermometer made it difficult to monitor daily temperatures accurately.
- In outpatient services, the refrigerator (stored in the dirty utility area) that was used by the allergy and immunology service was only checked when specialist nurses were present in clinic (which was three times per week). In addition, the temperature range recordings for the refrigerator in clinic five showed that it had consistently risen above eight degrees during September and October 2015 but there was no indication of any action taken.
- At the unannounced inspection we reviewed fridge temperatures again in the children's hospital and found there had been several occasions where fridges on wards 85, 84 and the bone marrow transplant unit where the temperature range had been recorded outside the recommended temperature range; this had not been highlighted to the ward manager and no actions had been taken.
- Patient group directive (PGD) documents were up to date and signed by staff. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. PGDs are used effectively to support patient access to medicines in a timely way.
- We observed medicines being given to children and young people by nursing staff. This was done in accordance with the prescription and safety checks were carried out during the administration. Children told us that staff always checked their name band and confirmed their personal details before giving them medicines.
- We reviewed a sample of prescription charts on each clinical area we visited in the children's hospital and found they were complete, legible and contained evidence of best practice in relation to medicines administration.
- PICU had access to 0.8 whole time equivalent (WTE) pharmacy cover. Based on the number of beds in the PICU, the pharmacy cover was lower than recommended guidance by 0.5 WTE. The paediatric intensive care society recommend daily pharmacist input equivalent to 0.07 WTE to 0.1 WTE for each single level 2 or 3 intensive care bed.

Records

- The children's hospital predominantly used paper-based records but also used an electronic system for patient observations, risk assessments, blood results and x-rays.
- We reviewed 52 sets of patient records across children and young people's services (including medical care

Services for children and young people

services, critical care, transition services, end of life care and surgery) which were generally completed to a good standard. However, loose-leaf documentation containing medical information was found in the majority of the records that we reviewed which could easily fall out, be mislaid or misfiled.

- Data from the trust showed that between 1% and 8% of patients were seen in outpatients on a daily basis without the full medical record being available. We reviewed the availability of paper records for outpatient clinics held on the afternoon of 4 November 2015 and the morning of 5 November 2015. Out of 144 records required for the afternoon clinics, 10 were missing with three in transit. For the morning clinic, 171 records were required and nine were unavailable. However, the introduction of the new electronic records system allowed clinical staff to view previous clinic letters and test results when paper medical records were not available. Staff were positive about this system which could be viewed on all desktop computers.
- A four bedded bay on ward 84 in the children's hospital was being used to store medical records. This room was openly accessible to patients and visitors to the ward as it was kept unlocked. The unit was in the process of relocating these records and this was on the departmental risk register.
- Records were stored in trolleys at or near the nurse's station on each ward. These trolleys were not locked, making them accessible to patients or visitors to the ward.
- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately. The mortuary records we reviewed, which included body release forms, were accurate, complete, and legible and up to date.

Safeguarding

- There were safeguarding policies and procedures in place that covered a range of issues including domestic violence and sexual abuse, female genital mutilation (FGM) and sexual exploitation. All staff we spoke to were familiar with FGM and had recently received extensive training on how to identify and report it. Staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed in March 2015 only 73% of staff had

completed level 2 and 81% of staff had completed level 1. By October 2015, 87% of staff in the Children's division had completed level 3 training. This was slightly below the trust's target 90%.

- All doctors and nurses working on the PICU/PHDU were required to complete level 3 child safeguarding training. Training records held in the department showed that the majority of staff had completed this training.
- Each medical ward had an electronic white board, known as 'patient safety at a glance' (PSAAG) that flagged any child where safeguarding concerns had been identified. The children on this board were only identified with their initials and the child had a discreet marker to ensure confidentiality was maintained.
- In medical care services, we reviewed six sets of safeguarding records and found they were not always completed appropriately in line with the trust policy. We found loose-leaf safeguarding notes in the records; some were kept in a plastic wallet in the front of the records. Some of the notes did not contain any patient identifiable information to identify which child they pertained to and some entries were not timed, signed or had the staff member's name printed on the record.
- On review of one set of records, we found that the safeguarding concerns were not clearly identified. They contained information relating to the mother's health but not the impact of this on the child. After reading the records it was unclear what the safeguarding concerns were and we had to seek clarification from the ward manager. On our unannounced inspection we found improvements had been made to these records and more recent episodes of care had clear concerns identified.
- The named safeguarding nurse attended the children's safeguarding group meeting. This group met regularly to discuss compliance with regulation, training, progress of audits and partnership working such as work with OFSTED and the Manchester safeguarding children board. The named safeguarding lead for the department cascaded information from the safeguarding meeting and provided mentoring and support to other staff.
- There was no paediatric liaison post at the children's hospital. This meant there was a lack of communication with community health professionals who were involved with the child in terms of admission and discharge. Community health professionals such as health visitors and school nurses were not routinely informed of the

Services for children and young people

child's hospital admission or care plan. This would ensure continuity of care between hospital and community services and ensure all professionals involved with the family are aware of the concerns.

- In outpatients, the records of children who did not attend for their appointment were reviewed by the clinician during the clinic (or within 24 hours) to ensure prompt follow up or GP notification.
- The children's hospital participated in the safeguarding audit called "Voice for Children". This audit was a statutory regional audit that looked at how safeguarding cases were handled across multi-agencies. Results showed staff required more support and training on safeguarding and that stronger communication links to integrate care across multidisciplinary teams were required.
- The local safeguarding action plan highlighted that the service had plans to produce material to ensure that children understood their right to be safe and who to ask for help. The action plan indicated that as of August 2015 this had not been achieved. We did not see evidence of this material during our inspection.

Mandatory training

- All staff undertook annual mandatory training levels 1 and 2, which included key topics such as infection control, information governance, health and safety, children and vulnerable adults safeguarding, equality and diversity, fire safety, manual handling and conflict resolution. Training was delivered via on-line courses as well as face to face.
- The overall mandatory training completion rate for staff across the Children's Hospital was 80% for level 1 and 84% for level 2. This meant the majority of staff had completed their mandatory training. However, this did not meet the trust's target of 90% compliance. Medical staff and allied health professionals (AHPs) were not included in this data. Due to the nature of their work, these staff worked on a number of different wards and within a number of different departments across the trust. Information supplied by the trust showed that trust wide, 74% of medical staff and 92% of AHPs had completed level 1 training and 63% of medical staff and 94% of AHPs had completed level 2.
- Ward managers in the children's hospital told us they were unable or unaware of how to obtain a copy of mandatory training for staff within their team and were considering having their own database for this. They

were therefore unsure of the staff compliance within their teams and were reliant on the learning and development department to highlight any areas of non-compliance to them.

Assessing and responding to patient risk

- The children's hospital utilised the electronic 'patient track' system that was used across the trust.
- Nursing staff used the Manchester Children's Early Warning System (ManChews). This was a standardised approach used for assessing a child's condition and to alert medical staff if their condition deteriorated. The score was inputted into 'patient track' and would automatically alert medical staff if the patient's condition deteriorated.
- Each ward in the children's hospital had a 'patient safety at a glance' system that identified risks associated with each patient, for example safeguarding, pain score and early warning score.
- On ward 85, we observed a baby receiving intravenous fluids who was visibly very oedematous (oedema is the medical term for fluid retention in the body. The build-up of fluid causes affected tissue to become swollen). The medical records showed they had not been weighed during their current admission (a period of seven days). The trust's policy did not identify how frequently children should be weighed or have criteria for which children should be weighed, such as oedematous children. This was brought to the attention of the ward manager and the baby was subsequently weighed.
- The PICU/PHDU did not have an outreach team to support wards when children deteriorated. Senior staff told us they realised having an outreach service would be of benefit and discussed plans for implementing a changed model of care in the future that would allow PHDU consultants to be involved in an outreach role.
- As part of the inspection, we observed the completion of the World Health Organization (WHO) 'Five Steps to Safer Surgery' checklist. The safety checking process was led in a clear and organised manner with full participation by all members of the multidisciplinary team. There was a democratic and collaborative approach to the completion of the safety checks.
- We observed the handover of children from theatre staff to recovery staff following surgery. The handovers were systematic and thorough. Recovery practitioners

Services for children and young people

supported children through the post-surgical period on a one to one basis. There were robust systems in place to manage the associated risks when caring for very sick children through the surgical process.

- At the time of our inspection, there was no transition register or other mechanism in place to monitor the number of children due to transition into adult services.
- Staff in the children's diabetes service told us that 20 young people had transitioned to adult services but there was a 50% non-attendance rate at their first appointment. Non-attendance was monitored by the team and young people who missed their appointment in the adult hospital were referred back to the children's hospital for their next appointment to try and make sure their treatment was not missed.
- There was a clear plan of care to follow for end of life despite the lack of formal standardised end of life documentation. Records showed clear discussions with parents regarding the best interests of the child in the event of deterioration in their condition.
- Staff carried out regular handovers of children on the wards. As part of this system, staff reviewed the children who were identified as being at the end of life, which included a review of their do not attempt cardio pulmonary resuscitation (DNACPR) status.
- Safety procedures were in place in radiology and we observed checklists being used to identify if children and young people were suitable for exposure to radiation. Staff obtained the name, address and date of birth of patients which is a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

Nursing staffing

- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The majority of wards we inspected in the children's hospital had sufficient numbers of trained nursing and support staff according to the Royal College of Nursing (RCN) guidelines with an appropriate skill mix to ensure that patients received the right level of care. Staffing rotas confirmed that staff numbers and skill mix were appropriate to meet the needs of children.
- A bed management meeting was held every morning where matrons and the bed management team would discuss staffing and patient numbers to ensure fair, needs-led distribution of staff.

- Medical care services had recently had a successful recruitment campaign to recruit qualified nursing staff. A large number of these had been placed on ward 85 as 14 out of 33 qualified nurses had left in a four month period between September and December 2014. A practice development nurse had been recruited onto the ward to ensure the new members of staff received the correct level of support and preceptorship. Staff rotas were completed to ensure there was a good mixture of both experienced and newly qualified staff on each shift.
- The Association for Peri-operative Practice (AfPP) guidelines were used to determine appropriate staffing levels for theatres and recovery. All recovery staff had a registered children's nurse qualification.
- In theatres, there were four whole time equivalent (WTE) vacancies. Two of these were for qualified staff and two were for support staff. At the time of the inspection, there were eight members of staff on sick leave. Staffing levels in theatres were identified on the children and young people's risk register. Although control measures were in place, it was recognised that "Some elective lists change at very short notice. If staff ring in sick on the day this may result in having to reduce staff in some theatres. The theatre coordinator must review staffing on a day to day basis and escalate any staffing concerns to the directorate manager. Lists may have to run with less than the recommended number of staff." (CMFT Children and Young People's Divisional Risk Register).
- Surgical services assessed the acuity and dependency of children on each ward every six months in order to inform establishment numbers. Each ward manager assessed acuity and dependency on a daily basis and shift co-ordinators assessed the same measure throughout the day. The tool used for assessment was a version of an adult's acuity and dependency assessment tool that had been adapted for children. Ward 78 was a pilot site for the development of the children's nursing acuity tool. Each ward ensured that the ward manager and a band 6 shift supervisor were supernumerary (surplus and not counted as part of the required staffing establishment) for each day shift, which is in line with Royal College of Nursing recommendations.
- However, when we visited ward 77 (a mixed surgical ward with 32 beds) on the unannounced inspection, there were eight qualified nurses to look after 28 patients. Approximately fifteen of these patients were aged two and under, 12 patients were over the age of

Services for children and young people

two and one of these patients required one qualified nurse to provide constant supervision. The Royal College of Nursing states that for patients aged two and under there should be one qualified nurse to care for every three patients and for patients over the age of two there should be one qualified nurse to care for every four patients. Taking account of this guidance and the requirement for one to one supervision for one patient, there should have been nine qualified nurses on duty to care for the patients on the ward on this date.

- Staffing for end of life care was the responsibility of all staff across the wards where end of life care was provided. Staff on the wards told us their work load was manageable. Ward staff told us they always prioritised care for a patient who was at the end of life and did what they could to ensure a staff member was with them.
- Agency and bank staff were used in the children's hospital to cover staffing shortages. Services tried to cover shifts with bank or agency staff who were familiar with the wards but new agency staff received good orientation to the ward at the start of their shift. Agency staff were not able to use the electronic observation system to record patient observations, therefore a regular member of staff had to complete this on their behalf.
- We observed a nursing handover in medical care services which was completed using a tape recorder. Staff pre-recorded the nursing handover that was subsequently played to the staff during the changeover at the start of their shift. This method could create risks such as staff not being able to ask questions at the time of handover. In addition, the cassette tape was recorded over daily and subsequently it was very difficult to ascertain which shift the handover referred to and there was a risk of information not being heard as the recording was very quick. We also observed that some information was missing from the tape, such as information about a child that was subject to safeguarding concerns.
- The PICU had staffing shortages mostly in the winter months and this was covered by their own staff doing overtime/agency. The PHDU was up to full staffing capacity after experiencing significant staffing challenges that had impacted on the beds that were available for use.
- In preparation for the new transition policy, RMCH sent out a self-assessment tool on 'transitional care best

practice' to 17 services at Manchester Royal Infirmary. The results showed 10 out of 17 adult services had a transition key worker / designated transition lead in their speciality. However, we visited three of the adult services who had said they had a transition key worker and found there wasn't one in place.

Medical staffing

- There was sufficient medical staff to meet the needs of the children in medical care services. The percentage of consultants working in paediatric medical services was 45%, this was higher than the England average of 35%. The percentage of registrars was 52%, this was higher than the England average of 51%. Only 2% of the medical staff were junior doctors which was lower than the England average of 7%.
- On-call consultant cover for each speciality in the children's hospital was provided 24 hours a day, seven days a week.
- Theatre was staffed 24 hours a day, seven days as well by a day and night shift system. This system ensured that a full consultant led team was available 24hrs a day. However, there was no second on-call system to support this team. Some staff raised this as a concern with the inspection team. This issue was highlighted on the children and young people's risk register. The control measure in place at the time of inspection was to contact off duty staff to see if they would come in but it was acknowledged this was a time consuming process (and not necessarily successful). The matter was due for review on 15 December 2015. Staff felt this was important as the last two weekends had witnessed two emergency cases where extra theatre staff were called in to deal with these emergencies.
- For patients with palliative/end of life needs, medical cover was provided on the general wards in the children's hospital.
- There was minimal access to specialist palliative medical support either in hours or out of hours (overnight or at weekends) other than two sessions from a community paediatrician with a special interest in palliative care. This was a very committed individual with a special interest in palliative care for children, who provided some clinical advice and support to develop palliative and end of life care in RMCH. There was no holiday cover for this post.
- There was a 'first on' consultant who undertook a "hot week" (Monday to Sunday 8am – 6pm) on PICU on a

Services for children and young people

rotational basis to provide continuity of consultant-led care. Newly admitted children were managed by this consultant. In addition on Monday to Friday there was a 'second on' consultant (8am to 6pm) who co-ordinated admissions and discharges. They were available to review critically ill patients anywhere in the hospital on request by the parent team. They also provided assistance to the 'first on' consultant on PICU when required. There was a third consultant on site 8am to 12 midday, Monday to Friday who undertook a consultant-led ward round on PHDU.

- Middle grade cover for PICU was provided by a team of 12 registrars and five advanced practitioners (two currently training). This provided a full shift rota with three or four doctors or advanced practitioners on days (8:30am – 9:30pm) and two or three at night (8:30pm – 8:30am).
- Three consultants rotated into the North West Transport Service (NWTs), which was a service hosted by the trust to transfer critically ill children.
- The care of the child or young person on the PHDU was managed by a combination of consultants. From Monday to Friday, 9am to 5pm, the paediatric intensivist had responsibility for PHDU. However, there was no consultant intensivist cover if this person was on holiday or sick. When the consultant was not available, the care was led by the relevant specialist team (such as gastroenterology, surgery). There were clinical risks associated with this model in respect of a lack of overall medical leadership, clinical accountability and timely clinical decision making. This had been identified as a risk and a plan to increase medical staffing on PHDU was said to be in place. However, this was not identified on the risk register.
- We observed a medical ward round in the children's hospital. This was led by a consultant and included a clinical fellow and a junior doctor. The ward round was thorough and child focused. The children and those close to them were involved in the care plan and information was explained well. However no nursing representative was present which meant they were not kept informed of any changes in the care plan.
- Junior doctors had a hospital 'huddle' on the night shift to ensure a more joined up approach was taken to cover the hospital rather than individual services. This also ensured equity of workloads.
- We reviewed the hospital's draft policy for transition services, which spoke of enrolling clinical leads for

transition in order to co-ordinate transitional care development within their departments and to ensure the dissemination and implementation of the policy. However, this was not consistently in place at the time of the inspection.

Major incident awareness and training

- There was a documented major incident plan which listed key risks that could affect the provision of care and treatment. Staff members were aware of how to locate this in the case of a major incident.
- An evacuation plan for PICU/PHDU was also in place and there had been a simulation testing this plan, where lessons had been learned and acted on.
- There was a bed management system that ensured managers in the children's hospital had a clear picture of where the demands and spare beds were in the hospital at any given time. This meant that in the case of space being needed in an emergency, the hospital was able to respond quickly and effectively.

Are services for children and young people effective?

Good



We have rated services for children and young people as 'Good' for Effective because;

Children and young people's needs were assessed appropriately. Care and treatment was delivered in line with evidence based guidance. Services contributed to national and local audits and implemented actions plans in areas they needed to improve. In order to benchmark its performance against comparable units the paediatric critical care service collected and submitted data to the paediatric intensive care audit network (PICANet). Audits showed that patient outcomes were in line with or better than the national average.

Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Pain relief was well managed. Pain scores were completed for all children and young people and there was a dedicated pain team. There was effective internal and external multi-disciplinary working. Consent was appropriately sought before any treatment was carried out. Appraisal rates for staff were better than the trust's

Services for children and young people

target. There were clear induction processes for staff which included competency assessments for procedures such as administration of medicines, infection control and discharge of patients.

However, there was no trust policy in place for young people transitioning into adult services. The trust was aware of this and was in the process of writing a draft policy which was due for completion by the end of 2015 and implementation at the beginning of 2016.

Work had been undertaken by the trust following the government review of the Liverpool care pathway and the decision to withdraw it in July 2014. The service planned to use a new comprehensive end of life documentation but at the time of our inspection, the documentation had not been implemented and there were no clear timescales for their rollout.

Evidence-based care and treatment

- The children's hospital used a combination of National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH) Standards to determine the care and treatment provided. An example of this was the NICE improving outcomes for chemotherapy training programme which advised that all qualified nurses working with paediatric oncology patients had completed specific training.
- The children's hospital demonstrated continuous patient data contributions to the paediatric intensive care audit network (PICANet). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- There were many evidence-based care pathways in place in the children's hospital that staff were familiar with, for example a North West-wide severe asthma pathway which the trust was instrumental in producing.
- A clinical pathway was in place for infants who may require attendance at the baby hip clinic. This was a one-stop assessment clinic which allowed babies to attend for investigation, consultation and treatment in one visit so reducing the need to attend for multiple appointments.
- The introduction of children's integrated recovery pathways (CHIRPS) for tonsillectomies was specifically aimed at improving the child's journey through the surgical process, from admission to discharge.

- Policies and procedures were in place and could be accessed via the trust's intranet. Staff were aware of how to access them.
- At the time of our visit, there was no policy in place for young people transitioning into adult services. The trust was aware of this and was in the process of writing a draft policy that was due for completion by the end of 2015 and implementation at the beginning of 2016. However, the trust was using the 'From bare feet to six feet' guidance from 2008, which was designed for transition in burns patients, rather than the more up to date "Ready Steady Go and Hello" transition programme from 2014.
- Whilst there was no trust wide pathway for transition, some individual services such as rheumatology and cystic fibrosis had comprehensive local transition procedures for young people with specific long-term health needs. For example, the cystic fibrosis service pathway involved four phases using the 'Ready, Steady, Go and Hello' transition programme. However, in phase one it stated that an individual transition plan should be designed with the patient and family, with individual goals and timescales, but at the time of our visit, we did not see any examples of this.
- Work had been undertaken by the trust following the government review of the Liverpool care pathway and the decision to withdraw it in July 2014. The service planned to use new comprehensive end of life documentation to support the multi-disciplinary team. At the time of our inspection, we were told the children's specific documentation was still at the printers and there were no clear timescales for their rollout. The training for use of this advanced care plan had not yet been launched in the children's hospital. The lack of an embedded end of life care plan may lead to inconsistencies in the delivery of end of life care across the trust.

Pain relief

- Pain relief was reviewed regularly and children and young people were involved in pain assessments. Staff utilised a paper based pain scoring tool. The paediatric pain profile tool was also used to assess pain in children with severe physical and learning disabilities. Pain relief was offered and administered when needed.

Services for children and young people

- Patients' pain scores were recorded on the electronic system which then transferred onto the wards' electronic 'patient safety at a glance' white board system.
- There was a dedicated pain team, led by an anaesthetist, who assisted staff to support children and young people with acute pain.
- Staff in the children's hospital used a 'grab a timer' process for the use of pain relief. Once a child had been given pain relief, staff set the timer for 30 minutes to remind them to assess the efficacy of the pain relief.
- In medical care services, we noted from discussion with a parent and subsequent review of the child's records, that one child did not have a pain assessment completed and was not given any pain relief when they had a painful procedure completed (reinsertion of a gripper needle). There was no documentation as to why pain relief was not offered or given to the child.
- End of life care services had adequate access to the necessary equipment, such as syringe drivers, to support the provision of appropriate pain relief.

Nutrition and hydration

- Staff within the surgical unit effectively managed the nutrition and hydration needs of children pre and post operatively. Nurses used the STAMP (screening tool for assessment of malnutrition in paediatrics) tool to assess the nutrition requirements of children.
- The food and drink provision had been reviewed since the last inspection in 2013, which highlighted that the choice of food across the hospital was limited. As a result, actions had been taken to improve food provision. Parents told us the menu choices had improved. Menu choices now catered for patients with special dietary requirements such as Halal and kosher.
- One young person being cared for on the cystic fibrosis ward said that the food had been of poor quality and the choice was limited but they had recently had the opportunity to work with dieticians to develop their own menu.
- Observation charts recorded intravenous infusions, parenteral nutrition and the patient's fluid balance, enabling staff to monitor the child's nutrition and hydration status. Fluid and diet sheets were completed appropriately within the child's records where required.
- Designated breastfeeding fridges were kept on each of the wards in the children's hospital which were easily accessible for mothers to store and retrieve breast milk.

Patient outcomes

- The children's hospital took part in the national diabetes audit. This identified that, over the past four years, there had been a sustained improvement in the percentage of children and young people with excellent diabetes control and there was a greater percentage of children and young people with controlled diabetes compared to the national data. An action plan was in place to make further improvements within this area.
- The patient outcomes for bone marrow transplant in the children's hospital were 20% better than the national average.
- The surgical unit appropriately monitored patient outcomes through internal audits and participation in national and international audits. For example, the trust submitted information to the ear, nose and throat (ENT) airway database (AIR). It also participated in the National Tracheostomy Safety Programme, as part of a paediatric multi-centre project and in the Trauma, Audit and Research Network (TARN), which shared data nationally. Using these data sets, the department was able to benchmark its performance. The results showed that the hospital's performance was in line with comparable hospitals.
- The average length of stay on surgical wards at RMCH varied minimally depending upon speciality. Performance in this area was comparable with similar hospitals in the country.
- The 28 day re-admission rate for surgical wards for the financial year of 2014 to 2015 was 3.3%, which was comparable with similar hospitals in the country.
- Regular audits were completed across medical care services, including the management of bronchiolitis; Crohn's disease, including remission and various audits in relation to the management of cystic fibrosis patients. Subsequent action plans were in place where areas for improvements had been identified.
- The monthly critical care quality dashboard showed a reduction to zero in July 2015 of central line related blood stream infections.
- Examination of the PICANet data reports from 2012-2014 indicated that RMCH performed well on each measure reported compared with other specialised children's hospitals of a similar size and case mix (exclusively

Services for children and young people

children with general conditions), For example, the report showed that 94.2% of critically ill children (757) were discharged alive in 2012, 96.2% (635) in 2013 and 94.3% (755) in 2014.

- The most recent PICANet report (November 2015) indicated that the units performed well when compared with other paediatric critical care units nationally. For example, the numbers of readmissions within 48 hours was 2.2% in 2012, 1.9% in 2013 and 2.4% in 2014.
- Audits were completed by the trust specialist palliative care team but only for adult end of life care. We asked for, but did not receive, any evidence of internal audits for children's end of life care services. RMCH did not submit data as part of the trust's submission to the National Care of the Dying Audit of Hospitals (NCDAH). However, there was representation from RMCH on the trust wide steering committee for end of life care for staff to share information.
- Diagnostic reference level (DRL) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part as part of the quality assurance process and results were stored on the departmental computer drive.
- Discrepancy meetings were held in radiology. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and thereby improve patient outcomes and safety. We observed meeting minutes from May, June and August 2015 and all had identified learning points from cases reviewed.
- There was no overarching performance quality dashboard to assess service provision for end of life care. Staff on wards where end of life care was provided measured quality locally including ward accreditation processes and quality performance dashboards.
- The trust had not carried out any audits of the outcomes for young people who had transitioned to adult services. However, a review in the diabetic service identified deficiencies in the transition process. This resulted in the transitional age for young people in the diabetic services being lowered from 12 years to 10 years old. In addition, the service identified that there was a 50% failure on attendance at adult clinics by young people who had transitioned from children's services. In response, a transition working group was set

up within the department to look at care pathways, offering more support to the young people at the time of transition. The aim was to share this work across clinical service units to improve attendance.

- We looked at three patient's notes for young people ready for transition. We found that one patient aged 19 years had received no documents or information in relation to transition. A 15 year old had completed a first stage of transition document at the age of 12 but nothing had been completed since. A 14 year old had also completed documentation for the first stage of transition (which was not dated) but had not completed anything since.

Competent staff

- Staff in the children's hospital received an annual appraisal. Trust data showed that 95% of staff in the medical care services had received their appraisal which was better than the trust target of 85%. Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good training opportunities.
- In critical care services, the latest figures showed that 81% of nursing staff had received an appraisal in the past 12 months. For allied health professionals the rate was 82% and for medical staff 77%.
- There were clear induction processes for staff which included competency assessments for procedures such as administration of medicines, infection control and discharge of patients. Newly appointed nursing staff told us they had received good support when they started in post from all members of the team. New staff also received a role specific induction which included shadow opportunities with specialist nurses.
- Twelve newly qualified staff nurses had started in post in a two month period on ward 84 in the children's hospital. To address this, the ward had employed a learning and development nurse to support them.
- Specialist nurses delivered role specific training within their area of expertise. For example, in paediatric oncology the specialist nurse ran a two day 'care of the child with cancer' course. Unfortunately, the training and support this specialist nurse was able to deliver was limited due to capacity as there was only one specialist nurse across the whole trust for both adults and children.
- Staff training and education for managing care of patients at the end of life had been provided on an

Services for children and young people

ongoing basis by the community paediatrician with an interest in palliative care. Junior doctors received training on end of life as part of their induction by the adult consultant for palliative care.

- The PICU had a dedicated training team for staff consisting of a band 7, band 6 and two band 5 nurses.
- The PICU had a comprehensive preceptorship package, with a fortnightly delivered mandatory generic package, followed by 6 weeks supernumerary period and then new staff were given a development package to complete in their first year on PICU.
- After the first year in PICU, the nurses were offered a mentorship course at university and could then undertake the advanced care of critically ill children module that was delivered locally.
- A well-established simulation programme was in place in critical care services that was consultant delivered and all multidisciplinary staff were involved.
- Staff who were dealing with young people of transitional age had received no specific training on adolescent health needs. The trust created a self-assessment tool, in the form of a questionnaire, to assess themselves against transitional care best practice, this was sent to a number of adult services. Out of the 17 self-assessments completed by adult services, only four said that they felt their staff were adequately trained in transition.
- Similarly, service managers told us that in line with best practice clinical champions for end of life should ideally be identified on all the wards where end of life care is provided. However, we found the majority of wards lacked named end of life nurses.
- A rolling programme of training in the use of syringe drivers was in place throughout the trust. Staff on the children's wards confirmed they were trained in the specific use of syringe drivers for children wards. Staff were knowledgeable on how to use the syringe drivers.
- The trust acknowledged the need to provide ongoing training to ensure staff were consistent in their approach to end of life documentation including DNACPR (do not attempt cardio pulmonary resuscitation).

Multidisciplinary working

- Good multidisciplinary team (MDT) working was noted in every area we visited. Clinical staff told us there were good working relationships between medical and nursing staff.

- There was good access to child and adolescent mental health services (CAMHS) on each of the children's wards. Staff reported they had a good working relationship and spoke with the CAMHS service daily.
- There were good links and working with other neighbouring trusts and specialist children's hospitals. Examples of good inter-trust working were given across oncology, severe asthma and diabetic
- Letters were sent out to patients' general practitioners (GP) to provide a summary of the consultation. However, following the introduction of the Integrated Clinical Environment (ICE) software, this process was being reviewed as GPs in the Central Manchester area could view letters and test results electronically.
- The ward rounds we observed in medical care services were only attended by either the medical team or nursing team, which meant there was limited multidisciplinary team discussion. Discussions from consultant ward rounds were documented in the medical notes.
- Patient care on the PICU was led by the consultant paediatric intensivists. However, there was a multidisciplinary ward round that had input from nursing, physiotherapy, pharmacist and others as appropriate.
- There was effective working with the North West Transport Service (NWTs), with some of the intensivists and anaesthetists rotating through the service.
- In the adult rheumatology service, there were some positive changes to practice in relation to transition services. The transition of young people previously just involved the doctors from children's and adult services. However, at the time of the inspection there was a multi-disciplinary handover which was still developing.
- A transition process was in place in the cystic fibrosis service and they had established links with a local hospital. Home visits were arranged by a multidisciplinary team, which included representatives from both child and adult services, to prepare and support the young person for their transition.
- A multi-disciplinary team from children and adult oncology met weekly to oversee young people of transitional age.

Seven-day services

Services for children and young people

- There were seven-day services within medical care services. There was consultant presence on all wards seven days a week. There was out of hours consultant on-call cover.
- Child and adolescent mental health services were available to provide support seven days a week to ensure that children and young people did not have to wait to have their mental health needs assessed.
- Play specialists and ward clerks in the children's hospital only worked Monday to Friday and no cover was provided during the weekend.
- A consultant intensivist provided 24-hour care on the PICU and PHDU at the weekend, supported by senior registrars and junior doctors. A second consultant was available on call. The physiotherapy team also provided a seven day service to the PICU 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.
- There were no regular outpatient clinics offered at weekends but additional clinics were scheduled on occasion at weekends to reduce waiting list pressures.
- The chaplaincy service was available every day of the year, 24 hours a day. The team ran an on call out of hours service.
- A priority recommendation from national reports is that hospitals should provide face to face specialist palliative care from at least 9am to 5pm , seven days per week, to support the care of dying patients and their families, carers or advocates. This was not routinely available in the Royal Manchester Children's Hospital. When a child on the oncology wards was identified as being at end of life, the key workers triggered their own on-call system for that individual child but this was not available to non-oncology patients in the rest of the children's hospital. The trust had submitted a business case for adult services but this did not include children's services.
- The children and young people's risk register showed that a risk had been identified in ensuring a robust on-call service to care for a deceased person out of hours. Temporary staff had been appointed to mitigate the risk and was due to be reviewed in 2016.
- The paediatric mortuary was not routinely staffed out of hours. There was an out of hours service for the Coroner's office which was contactable through the hospital switch board.

Access to information

- Staff used a new IT system, which was used across the trust, to record patient information. The system held all patient details such as personal details, previous attendance information, test results and observations. This allowed staff to review and manage records in different areas of the hospital.
- The radiology department used a system called the Picture Archiving and Communications System (PACS). The system was used across the trust and within a North West consortium of 10 trusts, allowing local and regional access to images. Previous images could be viewed by staff and some GPs who were linked to the IT system allowing for prompt access to results.
- Staff told us that while paper medical records were not always available, information about patients tests results and previous clinic letters were accessible on the electronic patient record system and staff were positive regarding its introduction.
- There were ample 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 and staff were familiar with how to access them. In addition there were mobile computers on the wards to support ward rounds, where patients' x-rays and blood results could be reviewed easily.
- The electronic patient safety white board system was available on each of the wards which allowed professionals to see at a glance the significant information they needed about each child or young person.
- The PICU/PHDU was not yet using an electronic patient information system. The paper based system in use was recognised as being a factor in the number of medicine and observations recording errors and near misses. This issue was top of the paediatric risk register and RMCH was in the advanced stages of deployment of an electronic system at the time of our inspection.
- Staff had access to a wide range of resources to support them caring for children and young people receiving end of life care. The on line documentation included information on current best practice such as symptom

Services for children and young people

management, spirituality guidelines, clinical pathways and paediatric pain management. The resources also included a signpost to the principles of care framework produced by the local strategic clinical network to guide staff in their decision making around end of life care.

Consent

- Consent was obtained from parents for each child and young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- Staff used the principles of the Gillick guidelines (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) when making decisions about the ability of a young person to consent to procedures.
- Consent had been sought from the child's parents prior to any surgical intervention in the children's hospital and these had been signed and dated.
- One young person with multiple complex health needs told us the consultant with responsibility for their care had tendencies to talk to their parents rather than directly to them.
- We requested data from the trust on any audits or review of the 'Do not attempt cardiopulmonary resuscitation' (DNACPR) process in the service. The most recent audit provided was from 2012 and although we found some informal monitoring of the completion of DNACPR documentation and process, we were not assured that the trust was able to fully assess how they were performing.
- We reviewed six completed DNACPR forms. The forms were fully completed with details of who was consulted in the process of a decision being made. However, we observed that DNACPR forms were not filed in patient's notes in an easily accessible way.
- Cases were presented to senior clinicians where there was a difference of opinion of what was best for the child. For example a parent may disagree with a clinical opinion that it was not in the best interests of the child to be resuscitated due to their life limiting condition. Although rare, some cases were taken to court for a decision when a consensus could not be agreed by the trust.

Are services for children and young people caring?

Good



We have rated services for children and young people as 'Good' for Caring because;

The majority of parents, carers and children were positive about the care and treatment provided. They felt supported, involved in healthcare decisions and received information in a manner they understood, although some improvements were required in transition services. Staff were compassionate, kind and respectful whilst delivering care. We saw several examples of staff going 'above and beyond' to provide person-centred, compassionate care to patients and their families, particularly in relation to end of life care.

Staff were child and family-focused and they looked at the family unit when completing their assessments. Good interactions were observed between staff and children, young people and their families. Staff demonstrated that they understood the impact of critical care interventions on children and young people and their families both emotionally and socially.

Compassionate care

- Throughout the inspection, we saw children, young people and their families and carers being treated with compassion, dignity and respect.
- The NHS Friends and Family Test conducted between April 2015 and September 2015 showed the percentage of patients that would recommend the medical care services to friends and family ranged from between 27% (ward 83) and 100% (wards 84). The response rate (23%) was lower than the England average (36%) indicating the scores were less likely to be representative of the opinions of the patients receiving care at the hospital.
- The wards in the children's hospital used a 'tops and pants' board where children were encouraged to share their views on what they liked and disliked about the ward.

Services for children and young people

- We observed many examples of compassionate care given to children and young people and those close to them based on individual needs. Staff provided reassurance and comfort to parents who were anxious or worried.
- On the bone marrow transplant unit, children were given a bead once they had completed each procedure. This was used as an incentive and reward to offer the children encouragement. Additionally the ward kept a box of gifts for the children to give to them at times when they were upset or anxious.
- Staff described several examples of when they had gone the “extra mile” to care for children and young people. This included managing to arrange for a child’s dog or other pet to come to the hospital as well as linking with external charities to grant wishes if at all possible.
- One family told us that some of the team members had travelled to their child’s home town in Scotland to talk to their child’s school and family about the child’s life limiting condition.
- Parents we spoke with were satisfied with the care, support and treatment their children received. However, the parent of one young person with complex needs told us the transition process had been discussed with them by a paediatric consultant, but not by the consultants from adult services, therefore they felt unsupported.
- We heard how a member of play staff, on their rest day, had gone above and beyond by accompanying a young person to their first adult service appointment. They did this as they felt that the transition process had not been effective because at the time, there was no transition policy in place.
- One 14 year old patient with multiple complex needs said they were unaware of which adult service they would be transitioning to. We also spoke to their parent, who said they had not been involved in discussions about where their child would transition to but would have liked to have been able to make an informed choice.
- We spoke to a parent of a patient living with cystic fibrosis who had expressed concerns that their child was not ready for transition to adult services, in response staff had listened and the young person’s transition was delayed.
- On ward 84, there was an ‘end of treatment’ bell which children and young people were invited to ring to celebrate reaching the end of their oncology treatment.
- Parents were encouraged to stay with their child on the children’s ward. There was a pull down bed at each bed space to enable parents and carers to stay on the ward. Also parents were given the option of staying at the hospital’s Ronald McDonald house. The 60 bedded Ronald McDonald house provided free ‘home from home’ accommodation for families should they need to stay over.

Emotional support

- The medical wards had good working relationships with child and adolescent mental health services (CAMHS). The service had daily contact with each ward to establish if any child or young person was in need of their services and if required would visit and assess the patient the same day.
- A record of achievement was kept on the long-term ventilation ward in the children’s hospital (ward 83) which made notes of first words and key milestones. This gave parents and carers emotional support in terms of celebrating achievements and sharing memories, as many of these children had been in hospital for several years.
- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in all areas visited. For example, on the oncology ward we observed staff supporting a young person and their carer when they were very anxious about going to theatre.
- The play therapists provided emotional support to patients and their families through distraction techniques for younger children.

Understanding and involvement of patients and those close to them

- Parents told us that staff listened to what they had to say and involved them and their children in the care and treatment of their baby/child. All parents said they were kept well-informed by staff. We observed a clinical intervention on a child where a full explanation of the procedure was given to the child and parent in an age appropriate manner.
- However, in transition services, young people were not given the opportunity to speak to a doctor alone routinely. This had been identified and was included in the new draft policy.

Services for children and young people

- The hospital had a number of clinical nurse specialists available for patients and their families to talk to about their condition and to provide support if they were given a new diagnosis.
- Staff provided families with emotional support during bereavement, they were aware of how to sensitively handle the situation.
- In terms of innovation, the service had developed the “rainbow clinic” to support previously bereaved parents in future pregnancies leading to a reduction in the number of subsequent stillbirths.
- Children’s cancer charities were actively involved with the oncology ward in the children’s hospital and representatives of the charity offered to sit with unaccompanied children to give those close to them a break. The charities also offered psychological support to young people and their families and helped finance resources for young people, such as Wi-Fi access.
- There was no funded psychology support for PICU/ PHDU, as per paediatric intensive care society standards. It was hoped the soon to be appointed family liaison nurse would improve the level of emotional support provided to children and families.
- Staff described memorial events and individual follow up with families following the death of their child. Follow up meetings with the specialist consultant were offered if families wanted to talk through their child death in more detail.

Are services for children and young people responsive?

Requires improvement



We have rated children and young people’s services as ‘Requires improvement’ for Responsive because;

Bed occupancy ranged from 87% (ward 75) and 95% (ward 84) for the period 1 May 2014 to 31 October 2015 which was worse than the national paediatric bed occupancy of 75.9% and the National Audit Office advice for bed occupancy. The bed management team were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available. Bays were occupied by male and female patients as they were arranged by age rather than sex. This meant that male

and female adolescents were often in beds next to each other. However, there were separate male and female toilet and bathroom facilities. The National Service Framework for mixed sex accommodation recommends that segregation by age is a more important issue than segregation by gender.

The outpatient service at the Royal Manchester Children’s Hospital (RMCH) did not meet national targets for referral to treatment times between April 2015 and September 2015. Waiting times for non-urgent magnetic resonance imaging (MRI) scanning, fluoroscopy and computerised tomography (CT) scanning exceeded the six week waiting time target between February 2015 and July 2015. In July 2015, 23.3% of patients waited more than 30 minutes to see a clinician. Long wait times for elective surgical treatment at RMCH remained a challenge with a number of specialities failing to meet the 18 week referral to treatment target. There was no overarching service planning or coordinated strategic approach for children and young people’s end of life care.

There were facilities to enable parents to be with their child at all times. We observed that each ward provided a child friendly environment. Interpreting services were available as required. The North West transfer and retrieval team worked closely with the critical care team to ensure swift and safe stabilisation and transfer of critically ill children. In the adult rheumatology unit, we saw innovative ideas and real compassion in the way they were transitioning young people into their adult service.

Service planning and delivery to meet the needs of local people

- The environment on each ward in the children’s hospital was child friendly with play rooms and teenage rooms available. However, three young people on the oncology ward identified that there were limited facilities for them. The teenage cancer trust had funded the youth room on the unit but the facilities were not fit for purpose; music on the juke box had not been updated for several years and there were no controllers for the games console meaning it couldn’t be used. In addition, games could only be used when a play specialist was in attendance on the ward as the games were locked away. The Wi-Fi on the ward was not working and staff had not reported this. As there were limited activities for patients and their medical conditions prevented them from leaving the ward, they felt this was having a negative impact on them.

Services for children and young people

- The radiology department was decorated with a space theme and the nine camera rooms were named and decorated to reflect each of the nine planets.
- We observed clear signage through the hospital to the outpatients, radiology and phlebotomy departments. Waiting areas with sufficient seating were available with access to toilets and water fountains.
- Ward 78 staff had developed a training programme to assist parents with the management of children with a tracheostomy at home. This development enabled children with a tracheostomy to be discharged home earlier than would otherwise have been the case.
- The 60 bedded Ronald McDonald house provided free 'home from home' accommodation for families should they need to stay over.
- Male and female adolescent patients needing inpatient care were either put in designated single rooms or in designed teenage bays. This meant that male and female adolescents were often in beds next to each other. However, there were separate male and female toilet and bathroom facilities. The National Service Framework for mixed sex accommodation recommends that segregation by age is a more important issue than segregation by gender.
- All of the young people and parents we spoke with in the children's hospital raised concerns about the standard of food, particularly that food and menus were not child friendly. Young people who had been in hospital for a number of months told us there was little variety and the food was very bland. This was supported by the results of the CQC children's survey in 2014. The trust were aware of this and had been working closely with the youth forum to redesign and improve menus.
- The North West Transfer Service (NWTS) had funding for only one emergency team, a second team was funded through winter pressure funding, which were non-recurring funds. NWTS provided a transfer service for emergency referrals to the hospital. The service was well resourced and could meet the needs of the children and their families.
- There were quiet rooms for parents in the children's hospital that were used to discuss patient care with families.
- In critical care services, there was no visitor waiting area for parents but a business case had been approved to make improvements to the unit for this to become possible including the introduction of lockers for families to place their valuables.
- In the adult rheumatology unit, we saw innovative ideas and real compassion in the way they were transitioning young people into their adult service. Staff had considered the young people who were due to transition and understood how they would feel entering a world of predominantly older people. As a result, young people had been involved in adapting the décor of the adult unit and information leaflets, to make them more youth friendly. The unit was also planning to conduct separate clinics in the evenings for young people, to improve attendance.
- The paediatric oncology service did not have a dedicated area for young people, however, a business plan had been submitted to expand the unit and services to provide a larger ward in order to facilitate this
- Young people age 17 years and above, had a choice as to whether they wanted to participate in education at the on-site school whilst a patient at the hospital.
- The oncology/haematology ward staff had close links with the community paediatric palliative care teams. Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care. However, in June 2015, the community team had reported through the end of life steering group that there was a lack of standardised end of life documentation shared between the community and the acute wards which may impact on the ability of the service to provide high quality care in a timely manner.
- There was no overarching service planning or coordinated strategic approach for children and young peoples end of life care.

Access and flow

- The bed management team were responsible for the co-ordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available. Bed meetings were held daily and were attended by a ward representative. They also discussed any action that was required when wards were at full capacity.
- Bed occupancy in the children's medical care services ranged from between 87% (ward 75) and 95% (ward 84) for the period 1 May 2014 to 31 October 2015. This was worse than the national paediatric bed occupancy average of 75.9%. The National Audit Office advises that

Services for children and young people

hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and an increased numbers of health care acquired infections.

- On occasion, patients were placed on wards that were not best suited to meet their needs due to lack of bed availability. Children or young people who were not on a ward specific to their condition, for example any oncology patients who did not have a bed on the oncology unit, were visited daily by the specialist nurses and consultants. This ensured they received the correct care and treatment.
- The RMCH divisional risk management review, May 2015 highlighted ongoing challenges in meeting the national 18 week referral to treatment time standards. Supporting documents from the meeting in relation to key performance standards referred to long waiting times for elective treatment within a number of specialities, for some time and despite concentrated efforts during 2014/15 which saw a reduction in a number of specialities, there were still patients on open and closed pathways waiting in excess of 46 weeks, but those on open pathways were treated within 52 weeks. It was reported that there were 693 patients waiting over 18 weeks for treatment at the time of the meeting.” From June to August 2015 there were approximately 221 patients waiting in the region of 52 weeks across all specialities. This ranged from 57 patients in total in June 2015 to 83 patients in total in August 2015.
- The trust annual report identified that paediatric urology faced significant waiting list pressures in 2015/16 and capacity was identified as insufficient to meet demand with an increase in the waiting list from 587 to 733 cases as of October 2014 and theatre capacity was a pressure in 2015/16.
- Patients were generally admitted to the medical wards via the emergency department. The hospital did not have an ‘open access’ policy for children to be admitted to the wards as it was felt beneficial for all children to be reviewed by staff in the emergency department to ensure admission was absolutely necessary.
- Delays in discharge were common from ward 83 due to difficulties in putting the correct package of care in place. This was due to the children on this ward having complex care needs.
- Care summaries were sent to the GP on discharge to ensure continuity of care within the community. GPs could telephone consultants and registrars for advice following discharge.
- The national referral to treatment target is for 95% of patients on non-admitted pathways to access treatment within a maximum of 18 weeks from referral. This target was consistently not met in the RMCH. Between April and September 2015, trust data showed referral to treatment times within 18 weeks for non-admitted pathways was 83.4%. Non admitted pathways refers to those patients whose treatment started during the month and did not involve admission to hospital. Managers described actions taken to address waiting times such as altering clinic start times to ensure the first appointment coincided with the arrival of medical staff.
- Additional clinics were also scheduled to improve access to clinics for patients in a timely manner. Rapid access clinics were held for specialities such as general paediatrics, ear, nose and throat, jaundiced babies and fractures and staff in cardiology told us that urgent cases could be seen within one day dependant on clinical need.
- The national waiting time target set by the Department of Health for non-urgent radiology diagnostic tests is six weeks. From February 2015 to July 2015 information from the trust showed this target was met for ultrasound scanning at RMCH. However in the same period, the number of children waiting more than 6 weeks for MRI scans consistently rose to a total of 59 in July 2015, with nine of those having waited more than 13 weeks. In fluoroscopy, three children waited up to nine weeks and for CT scanning, one child waited up to eight weeks.
- Reporting times for diagnostic investigations between April and September 2015 varied depending upon which test was performed. Over 99% of ultrasound scans were reported on within 14 days; however the amount of MRI reports available within 14 days ranged from 48% in May to 63% in September 2015.
- Between April 2015 and July 2015 the percentage of clinics cancelled within six weeks of the appointment date ranged from 2.1% to 2.5%; clinics cancelled more than six weeks before the date ranged from 23.8% to 24.6%. Cancellations were reported as being due to annual leave, the clinician attending at another hospital or the clinician no longer working with the trust.

Services for children and young people

- The trust had a number of patients who failed to attend for their appointments. Between April 2015 and September 2015 the 'did not attend' (DNA) rate was 11.3% which was higher (worse) than the average compared to other children's sites. Text reminders were sent to patients two weeks before their appointment and again one to two days before. The texting service also allowed appointments that were cancelled near to the clinic date to be offered to other patients reducing the number of lost appointments.
- A total of 45 children were taken out of region in the year preceding the inspection as there was no capacity in PICU. There were challenges in discharging patients from critical care services to the wards due to capacity on the wards. The nurses in charge of PICU/PHDU attended the hospital bed management meeting to discuss patient flow. All admissions to PICU, both internal and external referrals, were discussed with the consultant in charge, to ensure appropriate admission.
- An electronic system was in place to book a PICU bed for a theatre case. This was recorded as four slots in the summer and three in the winter. On the whole this seemed to work well.
- The service had clear processes in place to support children to be discharged to their preferred place of death, either through fast track home or hospice care. The service had strong links with the community paediatric palliative care nurses who liaised closely with ward staff. A rapid discharge checklist was completed prior to discharge to ensure that all the required support was in place. A drugs box was made available with all the appropriate medication for children to take home as part of a rapid discharge.
- However, there was no definitive data in relation to the number of patients dying in their preferred place of death or patients discharged within 24 hours from the service. Information we received from the trust following the inspection indicated that the SPCT had implemented an electronic system in October 2015 to capture this information. However, to provide the information for the twelve month period prior to the inspection would have required a manual audit of patient notes.
- Young people with multiple complex needs and/or a learning disability under the care of the paediatric

ophthalmology department, were often kept in the paediatric service until the age of 21 and did not transition to the Manchester Royal Eye Hospital as it was deemed more appropriate for their care.

Meeting people's individual needs

- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- All information leaflets were only available in English; however on the back of the leaflets, there were instructions, in several different languages for patients, identifying how they could obtain a copy in their preferred language.
- Staff on the long-term ventilation ward (ward 83) ensured that the ward felt like a homely environment for the children and young people as many of them had been resident in hospital for several years. They had access to an outdoor sensory garden and also activities, such as sports days and movie nights were held to enable them to participate in normal childhood activities.
- There were play specialists assigned to each ward in the children's hospital but they only covered core working hours Monday to Friday. We were told by staff, young people and parents they were excellent for keeping young children entertained but did not have the capacity to do a lot of work with older children and young people.
- All clinical requests for diagnostic tests were reviewed in radiology to detect if the patient required any additional support when attending the department. This allowed the play specialist based in radiology to complete a 'Reasonable Adjustments Person-Centred Assessment' form which helped to identify any individual need or intervention required when attending the department.
- Personal health passports were in place for young people in cardiology, which were issued to them by a charity for people with heart conditions.
- Staff at the hospital school informed us that young people with acquired brain injuries were taught in the hospital school, in place of the ward, to support their transition back to the school environment.
- Surgery services dealt with a significant number of children who have very complex needs. From theatres to post-operative care on a ward, the service was able to

Services for children and young people

adapt care plans to meet the needs of these children and their carers. The wider multidisciplinary team were an integral part of the care plan for children with complex needs.

- We spoke to a cardiologist nurse specialist who showed us a number of transitional information leaflets and booklets available for young people, however there were no adapted versions available for young people living with learning disabilities.
- The cystic fibrosis team provided an information pack designed for young people about the adult centre, which included a DVD explaining what will happen and information about the adult service.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. All families that we spoke to were aware of the function of the patient advice and liaison service, or how to access help.
- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process.
- There were a total of 11 complaints received by children's medical care services between August 2014 and August 2015. Staff were aware of any complaints that had been made about their own ward or department and any learning that had resulted from them.
- In critical care services, there had been eight lower level complaints in the past year relating to communication issues and clinical decision making. In addition, there had been nine higher level complaints in the past year.
- The ward managers in the children's hospital completed one intentional rounding each child and those close to them so they could raise any concerns. Intentional rounding is a structured process where nurses on wards carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

Are services for children and young people well-led?

Good



We have rated children and young people's services as 'Good' for Well-led. However, improvements were required in end of life care and transition services.

There was strong clinical and managerial leadership across the children and young people's services. The hospital had recently undergone an organisational restructure and had moved to having clinical service units. The clinical leads described a very clear vision for their departments. At the time of the inspection, we found this was not yet embedded in practice due to it being a new development. Services were effectively engaging with staff and patients to inform the improvement and development of their delivery.

There were robust governance structures in place which fed into the trust risk management committee. Monthly governance meetings were held and attended by key professionals. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

There was an overarching risk register and local risk registers held by each service. However, we found some risks identified by ward managers were not on the risk register, such as the lack of access to an appropriate pod system and children not being weighed on ward 85.

However, there was no clearly defined policy in place for transition services at the time of our inspection. This had been recognised by the trust and a policy was being developed. Similarly, there was no vision or strategy for children's end of life care. The lack of an overarching vision or strategy for these services meant that staff in the children's division did not have a clear understanding of what plans were in place for transition or children's end of life services.

Vision and strategy for this service

- The hospital clearly displayed their vision: 'To be a leading global Children's Hospital'
- The hospital strategy identified developments in children's surgical services as key to the development of RMCH's global identity. On inspection there were numerous examples of where surgical services were leading international development in areas such as

Services for children and young people

highly specialist neurosurgery, spinal surgery and urology. Senior medical and nursing staff espoused the same vision and were proud to aspire to being international leaders.

- The second strand to RMCH's stated vision and strategy was improved patient experience and outcomes. In terms of surgical services, an important aspect of this related to improving the referral to treatment times for the more routine urology and spinal surgery. These specialities were facing significant pressures and capacity was currently judged to be insufficient to meet demand. The strategy to increase capacity in order to meet current demand was to increase theatre utilisation at Trafford General Hospital.
- The hospital had recently undergone a change to the organisational structure and had moved to having clinical service units. The units were led by a clinical lead, a manager and a matron who all had a clear vision for their departments.
- The strategy for the medical clinical service units was aligned with the trust's operational development strategy and staff were aware of the trust's vision and values.
- Clinical leads in critical care, outlined that one of their aims was to remove the top down culture and have more collaborative working within the workforce.
- There was a clear vision and strategy for both PICU and PHDU articulated by staff.
- There was no clearly defined policy in place for transition services. The trust had assigned a lead nurse to create a transition policy, working together with a paediatric doctor. The policy was in development at the time of our inspection and was due to be in place by the end of 2015 (for implementation in early 2016). The aspirations for the trust were to develop multi-disciplinary adolescent outpatient departments and have an overarching strategy for transition. The aim was to develop a transitional sub-committee linked across the trust, predominately of nurses and doctors.
- There was no clear vision or strategy for children's end of life care. The lack of an overarching vision or strategy meant that staff in the children's division did not have a clear understanding of what plans were in place for children's end of life services.
- We met with one member of staff who had started to map out services available for children with end of life care needs. It was clear this was an important piece of

work which had not been identified by the service managers. We raised this with managers who agreed to support the work and share the learning across the services.

Governance, risk management and quality measurement

- Matrons held a weekly one to one meeting with the ward managers to offer support and guidance. Governance related issues, such as incidents and complaints were also discussed.
- A monthly unit governance meeting was held which was attended by ward managers, matrons and medical representation in addition to members of the governance team. These meetings were chaired by a consultant and included all relevant governance issues including incidents and themes, complaints and the departmental risk register.
- There was a robust governance structure in place within the medical clinical service units that fed into the trust risk management committee.
- Services measured quality and performance using quality dashboards which were on display in the main wards areas. Trust managers told us work had been started to review baseline performance in end of life care. However, at the time of inspection, there was no overarching performance quality dashboard or similar in place to assess service provision for end of life care.
- Safety huddles occurred at each nursing staff handover where lessons learned from incidents and complaints were shared.
- Team meetings had recently commenced on ward 75 chaired by band six staff. It was planned that these meetings would cover training and governance. Not all staff had had the opportunity to attend one of these meetings at the time of the inspection.
- The trust had an end of end life steering group which covered all aspects of end of life care but it was unclear from the membership what remit the group had to review children services. Trust senior managers told us a specific steering group for children's end of life care was due to be held. However, the lack of a planned date for the meeting did not assure us the service was proactively involved in planning the vision, strategy and operational delivery of children's end of life care.
- There was an overarching risk register and local risk registers held by each service in the children's hospital. The risks on the risk register had good control measures

Services for children and young people

in place and a review date set. Managers identified the departments' risks, understood the implications of those risks and discussed effective ways in mitigating and managing them. However in medical care services, we found some risks identified by ward managers that were not on the risk register, such as no access to an appropriate pod system and the issue of children not being weighed on ward 85. In outpatient and diagnostic services, security in radiology out of hours had been on the risk register since March 2013 and was reported to be an ongoing issue during our inspection.

- The children and young people service risk register indicated that some families felt they had been left unsupported following the death of their child. In 2015, the bereavement steering group had highlighted that there was an inequality in the support bereaved families received dependent on the specialities. This was confirmed during our conversation with staff members on both medical and surgical children's wards. The trust had responded to this risk by reviewing best practice to ensure that when possible, parents were accompanied to the mortuary for viewings out of hours.
- Critical incident summaries were shared with all staff via email and a newsletter, where trends were identified and learning disseminated.
- Transition services were managed by individual specialities within the hospital and not as a separate division, therefore there was no overall oversight or management of transition services across the trust.

Leadership of the service

- Nursing staff in the children's hospital felt their managers and matrons were visible and approachable. Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.
- Nursing staff in the children's hospital told us they did not feel the trust board were visible or understood their service. However they did receive trust emails to keep them updated on board developments. Some staff described attending a monthly "meet the executive team" event when staff could have "tea with the executives".
- There was effective nursing leadership at all levels in the children's hospital, with the matrons and Head of Nursing being visible and approachable, supporting the staff and families.

- There was effective medical leadership in the children's hospital with evidence that they worked well together.
- As part of our inspection of surgery services we spoke with two senior consultants, one of whom had been clinical director for a short period of time and another who was an established member of clinical leadership team. Both consultants spoke about surgical services passionately. They aimed to ensure that children's surgery was involved in local, national, and international benchmarking and audit. The difficulties that the service was experiencing was identified and understood by senior medical staff. Senior consultants were respected by junior doctors and identified as good clinical leaders.
- From discussion with the leads for transition services, it was clear they were not sure of their roles in the implementation of the new policy and procedures. We saw elements of good practices in transition services such as cystic fibrosis, diabetes and adult rheumatology, although the practices were not always followed through. The staff wanted to succeed in transition, but appeared to lack leadership and training.
- The trust had nominated an executive nurse lead to cover both children and young people and adult end of life care services three months prior to our inspection.
- The paediatric consultant with a specialist interest in children's palliative care was seen as a key figure in leading palliative and end of life care throughout both acute and community children's services but the input was limited due to the number of hours dedicated to the acute service.
- Morale of the senior staff was good and we witnessed good interaction between medical and nursing leadership.

Culture within the service

- There was an open and honest culture within the service in the children's hospital. Staff we spoke with were candid throughout our inspection about their service and the areas where they wanted to do better. Staff felt valued and respected.
- There had been 14 qualified nursing staff leave ward 85 between September and December 2014. However at the time of our inspection these vacant posts had been filled and staff reported a much improved culture on the ward.

Services for children and young people

- Staff in the children's hospital were very passionate about working in the organisation and were committed to providing high quality patient care.
- We met a number of very passionate staff who were trying to improve and champion end of life care in RMCH. Some staff said they would like to do more for end of life care but did not know what forums or staff to approach to share ideas or develop improvements. It was clear that staff "went the extra mile" for children at end of life although the systems to support them were not always in place.

Public engagement

- The medical clinical support unit was actively seeking the views of patients and their relatives by asking them to complete the NHS Friends and Family test.
- The children's survey was completed and the results were displayed on prominent noticeboards on all wards.
- The children's hospital ran a youth forum and all young people were welcome to participate. The forum was run by young people with support from staff and created a link between service users and senior managers. In the last 12 months the youth forum discussed food as a key issue and had developed a new menu with catering staff as a result.
- The children's oncology ward had mixed bay wards as a result of direct feedback from young people who expressed that they prefer to be in the same ward as other young people regardless of their sex.
- The ward areas in the children's hospital had a 'tops and pants' board where children and young people were asked to give their feedback on what they liked and disliked about the ward.
- The outpatient waiting area had a "thumbs up" or "thumbs down" board where children and their carers could feedback about their clinic visit and comments we observed were positive regarding doctors, nurses and play staff but negative with regards to waiting times and facilities.

Staff engagement

- The 'employee of the month' was displayed on ward notice boards. This ensured staff received praise for the work they did.
- Children and young people's services were involved in the trust's wider reward and recognition strategy. Staff

were recognised for their contributions to patient care from the perspective of the trust's core values of pride, respect, empathy, dignity, compassion and consideration.

- Staff were encouraged to be part of developing the critical care service within the Royal Manchester Children's Hospital.
- Blogs were written on the trust's intranet site to raise awareness of projects taking place.
- Psychological support was readily available for staff and they were aware of how to access it.

Innovation, improvement and sustainability







- The hospital had introduced a "Vision 2 Action" initiative to make savings without compromising on quality of care. This was an educational change leadership programme which placed emphasis on front line staff being the decision makers and leaders in order to achieve sustained improvement long term through greater staff engagement and accountability.
- Outpatients had introduced electronic self-check within the entrance to the RMCH and electronic calling screens in the waiting area and hospital restaurant. The aim of this was to reduce waiting times at reception check in and improve the patient experience. Patient feedback following this service development indicated that of 50 patients and families surveyed, 78% preferred self-check in to the reception check-in and 71% of patients preferred electronic calling to verbal calling.
- Ward 84 in the children's hospital used a mobile app to engage staff. This app was used to relay information to all staff and also to ask for help with staffing issues.
- The bone marrow transplantation service was internationally accredited and performed much better than the national average.
- The Baby Hip Clinic was one of the first examples of a one stop assessment and treatment service for children with developmental dysplasia of the hip in England. This innovation placed the clinical needs of children and ease of accessing assessment and treatment for parents at the forefront of service redesign.
- The trust introduction of a training programme which enabled parents to manage their child's tracheostomy at home was another example of the trust designing services, which placed children at the centre of innovation.
- In critical care services, there was innovative work undertaken in the area of learning disabilities and

Services for children and young people

autism. Much of these ideas had been generated from working with a specialist support primary school and included the paediatric pain profile and a virtual tour of PICU.

- The critical care units in the children's hospital had developed a working partnership with a local university to develop accredited courses for PICU and PHDU staff.
- The critical care multi-disciplinary team simulation training was being rolled out across the children's hospital.
- The training resource for students in the children's hospital, including mentor database, study leave folders and education records and resources had received national acclaim from the Nursing and Midwifery Council (NMC).
- The children's hospital had a dedicated National Institute for Health Research (NIHR) / Wellcome Trust Children's Clinical Research Facility on site; this facilitated complex inpatient clinical trials.
- Staff in some children's services and some adult services were keen to drive improvements in transition, but there was no evidence of collaboration. For example, adult rheumatology had some good ideas regarding transition, but appeared to be working in isolation rather than in collaboration with the children's unit.

End of life care

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

Information about the service

Patients with end of life care needs at the Manchester Royal Infirmary (MRI) and St Mary's Hospital are nursed on general wards.

Specialist end of life care is provided by a specialist palliative care team (SPCT) based at the MRI. The SPCT provide a range of training, education and support to staff providing end of life care in the trust. Advice and support includes: complex pain and symptom management, communication skills training, psychological/emotional assessment and support, spiritual care assessment and support, advance care planning and managing symptoms at end of life and care after death. The team also coordinates and plans care for patients on the wards who were at the end of their lives and supports and arranges rapid discharge for patients who want to die at home.

The hospital has a chaplaincy spiritual care department which reflects and serves the local population. The hospital has a bereavement team that supports relatives following the death of those close to them. The SPCT service operates between the hours of 9am and 5pm five days per week, excluding bank holidays. There is access to 24 hour specialist palliative care advice via the local hospice advice line.

From January 2014 to December 2014 there were 1160 in-hospital deaths at the trust. From April 2014 to March 2015, 982 patients had been referred to the specialist palliative care team. This was an increase in 33% from the previous period April 2013 to March 2014.

We inspected the end of life care services at MRI as part of our announced inspection on 3 to 6 November 2015. We visited eight wards where end of life care could be provided. We also visited the chapel/multi-faith room, the hospital mortuary, viewing room and bereavement services.

We observed care and spoke with 12 patients and four relatives, 39 members of staff across all disciplines, including bereavement services, mortuary staff, chaplaincy, nursing staff, medical staff and porters. We met with the SPCT, team leader and the palliative care consultant to gain an overview of the palliative and end of life service.

End of life care

Summary of findings

We have rated end of life care services as 'Requires improvement' overall because;

There was a dedicated specialist palliative care team (SPCT) who provided support to patients at end of life and to staff caring for patients on the general wards. However, access to specialist palliative care was not available seven days a week other than an advice line provided by the local hospice. Consultant staffing was below the recommended levels for palliative/end of life care. The trust had identified that the service required improvement and had submitted a business case to increase both nursing and medical staff to meet the demands on the SPCT.

Whilst some progress had been made to meet national guidance following the removal of the Liverpool care pathway in 2014 there was some confusion and a lack of clarity about what alternative documentation was in place. There was a need to identify and formalise a clear strategy for end of life care throughout adult services. The trust had identified an executive director to lead end of life care for the trust, this was introduced at the time of our inspection.

End of life care provided by staff on wards was found to be safe and personalised to the needs of individual patients. Staff worked hard to meet the individual patient's needs and wishes. They were caring and committed to supporting people at end of life. Individual clinical teams used a combination of evidence based guidance, such as National Institute for Health and Care Excellence (NICE) guidance, Royal Colleges' guidance and quality standards to determine the care provided.

Are end of life care services safe?

Good



We have rated end of life care services as 'Good' for Safe because;

The SPCT were able to describe safeguarding procedures and provided us with examples of how they would be used. Staff were aware of how to report an incident or raise a concern. We saw some examples of how learning was shared and practice had changed in other disciplines providing end of life care services. Records were completed legibly and were up to date. Records included test results, risk assessments and medical and nursing records. Equipment required for end of life care, for example syringe drivers and infusion pumps were not always fit for purpose or available when needed. Medicines, including controlled drugs, were stored securely and administered in line with best practice.

Staff took part in mortality and morbidity meetings where individual cases of patient deaths were presented and discussed. Mortality reviews and inquests were discussed at a monthly divisional mortality committee. The service aimed to review 30% of deaths, however information provided by the trust showed that between June 2014 and June 2015, this target was met only four times and there were four times when no reviews were carried out at all. Palliative care consultant staffing was below recommended levels. The need for sufficient specialist palliative care staff to meet the demand for the service had been identified and was on the end of life risk register. A business case had been submitted to seek investment in services to enable staff to respond in a timely manner.

Incidents

- No serious incidents were recorded between August 2014 and July 2015 for end of life care at the Manchester Royal Infirmary (MRI).
- Staff on the wards where end of life care was provided, were encouraged to report incidents and could describe how to report incidents using the online reporting system; this was demonstrated during our inspection.
- The specialist palliative care team (SPCT) were aware of how to report an incident or concern and gave examples of what they would report. Staff told us they would

End of life care

report incidents when visiting patients on the wards and were able to show us how they would access and submit an incident report. They told us they did not always receive feedback on the outcome of incidents they had reported.

- By monitoring the incidents relating to end of life care, the SPCT were able to identify themes and influence training and policy to improve the quality of end of life care across the trust. We reviewed the terms of reference for the end of life steering group which had a responsibility to review any root cause analysis or investigations into end of life care in the trust. Records from these meetings confirmed this was happening.
- Mortuary staff said they would complete an incident form if they had concerns regarding either the moving and handling or presentation of a deceased patient. Mortuary staff were able to describe improvements to the service after an incident, where the transfer policy for deceased patients had not been followed. A checklist had been introduced to improve practice and ensure appropriate care of a deceased person.
- Staff took part in mortality and morbidity meetings where individual cases of patient deaths were presented and discussed. Mortality reviews and inquests were discussed at a monthly divisional mortality committee. The service aimed to review 30% of deaths; however information provided by the trust showed that between June 2014 and June 2015, this target was met only four times and there were four times when no reviews were carried out at all. Mortality reviews are an opportunity for learning and increasing awareness for staff, to ensure that care is safe
- A trust wide duty of candour policy was in place which detailed how patients should be communicated with following a reportable patient safety incident. The duty of candour is a regulatory requirement. The aim of the 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. Medical and nursing staff demonstrated an understanding of their individual responsibilities in relation to the duty of candour.

Cleanliness, infection control and hygiene

- Mortuary staff were aware of current infection prevention and control guidelines. We observed that the mortuary was visibly clean, well ventilated and free of odours.

- Policies for the prevention and control of infection and hand hygiene were available on the trust's intranet and staff could show us how to access them.
- Staff were observed using personal hand sanitising equipment when entering wards to visit patients and personal protective equipment was available for the SPCT team if required.

Environment and Equipment

- Mortuary services were licensed by the Human Tissue Authority (HTA). HTA certification was visible in the mortuary. The HTA licenses and inspects organisations that remove, store and use tissue for medical treatment, post-mortem examination and teaching. HTA sets standards that licensed establishments must meet on: consent; governance and quality systems; premises, facilities and equipment; and disposal.
- Pressure-relieving equipment, including mattresses, was available for patients who required them. We saw these mattresses in use on the AMU where an end of life patient was being nursed on an air mattress.
- Records included a syringe pump monitoring checklist which included four hourly safety prompts and checks of the needle site, battery and volume of infusion remaining in the syringe. The use of syringe drivers had been supported by regular and on-going staff training; however this was not mandatory and was dependent on wards being able to release staff.
- In 2011, the National Patient Safety Agency recommended that a particular range of syringe drivers should be removed by the end of 2015. Replacement syringe drivers were provided in accordance with this guidance. Staff reported syringe drivers could be secured if required as part of the patients' treatment package.
- We looked at all the incidents relating to end of life care in the hospital and found ten incidents in the last twelve months when syringe drivers had not been available on a ward when required. During our inspection we found on three wards that syringe drivers were either unavailable or in one case was broken. We reported this to senior staff at the time of our inspection.
- In some ward areas staff told us they used a specific type of infusion pump. End of life drugs should not be administered using these devices. Senior managers told us this type of pump would only be used in rare

End of life care

instances when an alternative pump was not available. Staff were aware of the need to generate an incident report if they used an identified pump for end of life medications.

- Senior managers confirmed that the issue of syringe drivers was on the risk register and data provided by the trust confirmed this. The risk was due for review in December 2015. A paper presented in August 2015 confirmed that work was on-going by the Medical Engineering and Maintenance Department to ensure that the appropriate infusion pumps were available.
- A maintenance process was in place to ensure that medical devices were fit for purpose. Data showed that as of August 2015 fifteen percent of equipment related to end of life care such as syringe drivers had not been serviced in the last twelve months. This was being addressed by the medical devices committee and an improvement plan was in place.

Medicines

- In the areas we visited, medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. The keys for the controlled drugs were kept separately for increased security.
- Staff followed the trust's medicines management policy and managed controlled drugs in accordance with the controlled drugs regulations 2013. We observed medicines being given to patients by nursing staff; this was done in accordance with the prescription and safety checks were carried out during the administration.
- Patients told us that staff always checked their name band and confirmed their personal details before giving them medicines.
- Medical staff followed the trust's clinical guidelines on medication prescribing. Guidance included prescribing appropriate end of life medicines to manage a patient's pain, anxiety and other symptoms.
- Guidance for anticipatory medicines was shown on prescription charts for patients.

Records

- We looked at 17 care records and plans used to assess and record patients' care needs. Shortfalls were identified in seven of the records we reviewed. These included lack of detail around the management of pain, oral care and nutritional needs. The hospital used both electronic and paper based patient records. At the time

of inspection, a generic care plan template was used for patients at the end of life. These records were clear, legible and up to date. Records included test results, risk assessments and medical and nursing records.

- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately. The mortuary records we reviewed, which included body release forms, were accurate, complete, legible and up to date.
- The community team had reported through the end of life steering group in June 2015, that there was a lack of standardised end of life documentation shared between the community and the acute wards which may impact on the ability of the services to provide high quality care in a timely manner.
- We looked at seven patient records where DNACPR forms were in place and found some examples of documented discussions with patients and relatives about treatment decisions. We saw evidence of appropriate doctor/consultant sign off of DNACPR decisions. However, three records did not document whether discussions had taken place with the family regarding the DNACPR decisions. Good practice indicates that clear communication and involvement of the patient and their loved ones is central when making decisions about DNACPR decisions.

Safeguarding

- The trust induction and mandatory training policy identified that children and adults safeguarding level 1(basic) and level 2 (advanced) training were provided as part of the corporate or clinical annual mandatory training.
- Records showed that 100% of staff in the specialist palliative care team had completed level 2 safeguarding training for adults and children, against a trust target of 90%.
- Mandatory training in safeguarding children and vulnerable adults also included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- There were appropriate trust wide protocols for safeguarding adults and children. Staff on wards where palliative or end of life care took place, were aware of the requirements of their role and responsibilities in relation to safeguarding and knew how to refer a safeguarding issue to protect adults and children from abuse.

End of life care

Mandatory training

- The SPCT were up to date with their mandatory training which was undertaken on an annual basis. Packages of mandatory training were available for different staff groups, for example level 1 training was provided for all staff groups and included infection control and prevention, safeguarding, health and safety and major incident awareness training.
- End of life care training for registered nurses across the trust, consisted of a one day 'Introduction to palliative care' course; this was part of the trust mandatory training programme and included an e-learning module on end of life care as part of the trust induction for new registered nurses.
- Training was recorded on the electronic training management system. Staff reported this system was not always effective as information was not always accessible and some records showed as being out of date. Ward managers showed us paper records they used to keep track of staff compliance.

Assessing and responding to patient risk

- The trust had an electronic flagging system in place within the Patient Administration System (PAS) on the central site. For example, it highlighted a vulnerable adult or child who required additional support. The PAS recorded the patient's demographics (e.g. name, home address, date of birth) and detailed all patient contact with the hospital, both outpatient and inpatient.
- A system using an early warning score (EWS) was in place to assist staff in identifying patients when their condition was deteriorating. An EWS is the calculation of a score based on the results of physiological observations including heart rate, blood pressure, respiratory rate, temperature, urine output and level of consciousness.
- There was a system in place called 'patient track'. Staff used handheld computer devices for recording observations which automatically calculated the EWS. An EWS of three or above would trigger a review by nursing and medical staff on the ward. A score of five or above triggered an automatic call to the duty medical registrar and nursing bleep holder to come and assess the patient. This reduced the risk of a deteriorating patient being missed.

- Patients' documentation would be transferred to a care of the dying care plan when it was recognised that the patient was expected to die within hours or a few days.
- We reviewed 17 care records and found the majority of these showed assessment of patient risk and an appropriate response taken. Risk assessments such as nutritional assessment, pressure ulcer risk assessments and bed rails assessments had been undertaken and were documented fully. However, patients were not formally assessed as to whether these charts were appropriate for use with patients at the end of life. Five of the charts were not fully completed and staff therefore did not have accurate assessments of a patient's condition, such as if they were properly hydrated. However, staff were confident the introduction of the new 'Priorities of care for adult patient at end of life' care plan document would be easier to complete and would assist them in using charts appropriately or deciding whether to withdraw their use.

Nursing staffing

- Staffing for end of life care was the responsibility of all staff across the wards where end of life care was provided and was not the sole responsibility of the SPCT. Staff on the wards told us their work load was manageable. Ward staff prioritised care for a patient who was at the end of life and did what they could to ensure a staff member was with them.
- Six patients and their families reported they felt staff appeared to be very busy on the wards we visited. The relatives did not feel this had compromised care but would prefer staff to have more time to respond to their loved ones needs and be available to talk through any concerns.
- The SPCT team comprised of 2.8 whole time equivalent (WTE) clinical nurse specialists, 3 WTE associate band 6 nurses and 1.2 WTE allied health professionals.
- The team had recently undergone some changes and had filled a long term vacancy for the team manager who was due to start in post after our inspection visit.
- Data showed there had been a 33% increase in the demand for services in the twelve months prior to our inspection. The need for sufficient specialist palliative care staff to meet the demand for the service had been identified by the service and was on the end of life risk

End of life care

register. A business case had been submitted to seek investment in services to enable staff to respond in a timely manner and provide access seven days a week and out of hours.

- The service managers told us that in line with best practice, clinical champions for end of life should ideally be identified on all the wards where end of life care is provided. However, we found the majority of wards lacked named end of life nurses. This may impact on the trust's ability to ensure staff receive up to date information on end of life care.
- Staff in the mortuary worked in pairs to safely carry out a number of activities.

Medical staffing

- For patients with palliative/end of life care needs, medical cover was provided on the general wards in MRI.
- There was one part time 0.6 WTE palliative care consultant for the MRI. This was below the recommended staffing levels outlined by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance, which states there should be a minimum of one WTE consultant per 250 beds. The MRI alone had approximately 663 beds which would equate to 2.7 WTE consultants.
- Weekend and out of hours on call advice was obtained via an advice line provided by a local hospice. The SPCT could also phone the consultant out of hours; however this was done on a 'good will' basis. Staff told us he "would come to see a patient if desperate."

Major incident awareness and training

- The trust had an emergency planning policy which detailed circumstances that could affect the delivery of services. The policy identified the roles and responsibilities of staff to ensure continued service provision in the event of a major incident.
- In the event of a major incident the mortuary staff had a policy in place for staff to follow including how to arrange for additional refrigerated mortuary space.

Are end of life care services effective?

Requires improvement



We have rated end of life care services as 'Requires improvement' for Effective because;

We were not assured that sufficient progress had been made to meet national guidance following the removal of the Liverpool care pathway nationally in 2014. An approved individualised care plan document had not yet been fully implemented across the trust and plans showed the implementation would not be mandatory for every ward. The lack of an embedded end of life care plan may lead to inconsistencies in the delivery of end of life care across the trust. At the time of inspection, a generic care plan template was used for patients at the end of life. Data provided by the trust showed that in the period January 2015 to March 2015 only 48% of patients at end of life had a completed individual plan of care.

The specialist palliative care service was not available seven days a week which was not in line with national recommendations. There were issues around the use of two types of infusion pumps/syringe drivers and the lack of staff competencies in using these. We raised these issues with trust at the time of inspection. The trust responded to our concerns and has provided us with a training plan and an update on progress since the inspection to address these issues further. There was no overarching performance quality dashboard to assess service provision for end of life care. This meant we were not assured that the service was effectively monitoring the quality and outcome of care delivered at end of life and palliative care. However, staff on wards where end of life care was provided did measure quality locally including through the ward accreditation process and through use of quality performance dashboards.

In the National Care of the Dying Audit for Hospitals (NCDAH) 2013/2014, the trust performed better than average for eight out of the ten clinical key indicators and achieved four out of the seven organisational key indicators. As a result the trust had developed an action plan to detail how the recommendations made would be achieved. The service still had a number of key actions to

End of life care

complete, in particular access to specialist support for care in the last hours of life and the development of formal feedback processes regarding bereaved relatives/friends views of care delivery.

Evidence-based care and treatment

- The specialist palliative care team (SPCT) worked in line with best practice and national guidelines such as the National Institute for Health and Care Excellence (NICE) quality standard 13: End of life care for adults.
- Regular clinical audits took place in relation to end of life care including pain management and a three monthly review of all expected deaths in MRI.
- The trust initially introduced an individualised care plan to replace the 'Liverpool care pathway for the dying patient' which was removed nationally in 2014. The care plan had been produced by the local strategic clinical network but this was withdrawn following feedback from nursing staff at the beginning of 2015. Despite being ratified in August 2015, the revised documentation had not yet been fully implemented across the trust and plans showed that the implementation would not be mandatory for every ward. The lack of an embedded end of life care plan may lead to inconsistencies in the delivery of end of life care across the trust.
- The training for use of this advanced care plan had just been launched on two wards at the time of our inspection. We saw this in place for one patient, which meant staff were able to deliver care in accordance with the patient's individual preferences and wishes.

Pain relief

- The service performed in line with the England average for the provision of protocols for the appropriate prescription of medicines for the five key symptoms at the end of life.
- Two of the five specialist nurses were nurse prescribers and were able to prescribe medication for This was good practice as it enabled nurses to give symptomatic relief without delay.
- We reviewed five medication administration record charts in a number of wards. Nursing staff said they felt end of life medication was well managed and patients received effective symptom control. However we found that in four out of the five charts the anticipatory medicines had not been fully completed.

- On the emergency medical unit we observed medication was administered for a patient experiencing breakthrough pain in line with their prescribed medication to relieve their symptoms.
- The wards we visited stocked the appropriate medication required for syringe driver pumps (a method of continuous delivery of medicines). A pharmacist confirmed these drugs would be made readily available so there would not be delays in treatment.

Nutrition and hydration

- The trust participated in the 2013/14 National Care of the Dying Audit for Hospitals (NCDHAH), which showed the trust scored 52% for the "review of the patient's nutritional requirements" indicator. This was better than the national average of 41%.
- Ward staff showed us the new hydration pathway. We were told that all patients should be assessed for factors influencing hydration within 6 hours of admission. The trust was due to audit the new pathway early 2016.
- We observed that "food charts" didn't state 'offered' and 'refused' to enable staff to accurately monitor a person's food intake.

Patient outcomes

- The results of the 2013/2014 NCDHAH were predominantly positive. The trust performed better than average for eight out of the ten clinical key indicators and met four out of seven key national performance indicators for organisations providing end of life care. Following the audit, the trust had developed an action plan to detail how the recommendations made would be achieved.
- The service still had a number of key actions to complete, in particular the roll out of the final replacement of the Liverpool pathway, access to specialist support for care in the last hours of life and formal feedback processes regarding bereaved relatives/friends views of care delivery.
- Results from an internal audit carried out at the beginning of 2015 highlighted the need to ensure holistic care assessment and planning, documentation and communication for individuals identified as potentially being in their final hours/days of life. The audit also showed that of individuals recognised as dying, only 48% had an individual plan of care based on

End of life care

the five areas considered central to end of life care. The standard expected to be completed was 100%. The SPCT had an action plan in place to carry out a further audit after the roll out of the replacement pathway.

- A senior manager told us that whilst it was mandatory that clinical staff address all the areas identified in the care plans, it was not mandatory that they complete the care plan. This lack of focus and clarity about what was required for individuals did not assure us that there were robust processes in place for staff to follow in order to provide appropriate end of life care.
- The trust did not participate in the Gold Standards Framework (GSF) accreditation scheme. GSF is an independent accreditation scheme, the aim of which is to improve the quality, coordination and organization of care leading to better patient outcomes. The trust did have an internal accreditation scheme which included key areas such as feeling safe, food and nutrition, privacy and dignity, pain management, involving patients and carers, meeting personal hygiene needs and the patient's opinion of the overall quality of the patient experience. However end of life care was not identified as a specific area for review.
- There was no overarching performance quality dashboard to assess service provision for end of life care. This meant we were not assured that the service was effectively monitoring the quality and outcome of care delivered at end of life and palliative care. However, staff on wards would review EOL patients' care as part of the ward accreditation process if patients were at the end of life.

Competent staff

- The trust acknowledged the need to ensure training was on-going to ensure staff were consistent in their approach to end of life documentation including DNACPR (do not attempt cardio pulmonary resuscitation).
- There were issues around the use of two types of infusion pumps/syringe drivers and the lack of staff competencies in using these. We raised these issues with the trust at the time of inspection. The trust responded to our concerns and has provided us with a training plan and an update on progress since the inspection to address these issues further.
- Staff training for the use of syringe driver pumps was available, however this was not mandatory. Attendance

at training was ad hoc and dependent on wards being able to release staff. The SPCT had recently held medical device training days and were continuing with a rolling programme of drop in sessions for staff to attend.

- In addition to mandatory training, the SPCT held a "hot topic" in June to raise awareness of the 'five priorities of care' for end of life. Sessions were delivered twice a day for the month. Data provided by the trust showed that 227 staff attended these awareness sessions.
- Staff training and education for managing care of patients at the end of life had been provided on an ongoing basis by the SPCT. Junior doctors had training on end of life as part of their induction by the adult consultant for palliative care. Training and updates in DNACPR, advanced communication skills, palliative care and oncology were available. This training was mandatory for junior doctors and band 5 nurses.
- 100% of the eligible SPCT staff had completed an appraisal in the last twelve months prior to our inspection. The use of appraisals is important to ensure staff have the opportunity to discuss any developmental needs or support required to help them carry out their role.

Multidisciplinary working

- The SPCT worked across MRI and St Mary's Hospital as part of the multidisciplinary team (MDT) which also included the rapid discharge team, consultant in individual specialities, nursing staff and community staff.
- The trust had developed rapid discharge guidelines which promoted effective communication between all relevant parties, ensuring appropriate documentation was completed to facilitate effective, safe management of the dying person and those identified as important to them.
- The consultant in palliative care also worked in the local hospice which ensured close working links between the two organisations.
- We saw evidence of joint working between the community and acute palliative and end of life care teams.
- MDT meetings were held on the wards to discuss and manage patient risk and concerns. Patients at the end of life were included in the discussion so all disciplines could contribute to their care. The SPCT had regular meetings to discuss individual patients. Staff told us they supported other health professionals to recognise

End of life care

and consider when patients may be approaching end of life. The different individual clinical multidisciplinary teams worked well together to coordinate and plan the care for patients at the end of life.

- The local ambulance trust was a key player within the rapid discharge plan and was an active part of the multidisciplinary team.
- The palliative care consultant tried to attend “board round” every day on wards where end of life care was routinely provided.

Seven-day services

- Ward staff told us the SPCT was a responsive, supportive service. The SPCT were available on the MRI site from 9am to 5pm, Monday to Friday. This was not in line with recommendations outlined in the ‘National care of the dying audit for hospitals, England: National report’, May 2014.
- Out-of-hours specialist telephone advice was provided by the local hospice. Medical cover at the weekend was provided by the on-call doctors from other specialities who were not necessarily familiar with the patients. As a result there was a risk that appropriate end of life care may not be provided over bank holidays and weekends.
- The specialist palliative care team told us they ensured patients referred to them had a plan of care in place to meet their needs over the weekend period.
- Radiology services were led by a consultant and were available on Saturday and Sunday until 6pm and then on call over the weekend.
- Outside normal working hours, there was an on-call pharmacist to dispense urgent medications. Staff told us this sometimes meant there were delays in discharging patients. This was recorded through the discharge planning team and monitored through the trust governance processes.
- The chaplaincy service provided 24-hour on-call support for patients and relatives.
- The adult mortuary was not routinely staffed out of hours. There was an out of hour’s service for the coroner’s office that was contactable through the hospital switch board.

Access to information

- We reviewed 17 records as part of the inspection. In some of the records reviewed, we found documentation

did not always provide sufficient information for staff to deliver care in accordance with the patient’s individual preferences and wishes such as preferred place of death.

- Staff had access to a wide range of resources to support them caring for people at end of life. The on line documentation included information on current best practice including symptom management, spirituality guidelines, clinical pathways and pain management. The resources also included a signpost to the “principles of care framework” produced by the local strategic clinical network to guide staff in their decision making around end of life care.
- When a person died, staff had access to online information that may be required following the death of a person for example, information on referral to the coroner and information about the bereavement service.
- Trust managers told us they had started a project to introduce an electronic palliative care coordination system (EPAACS) in line with national good practice. However this was in an early stage and we did not see evidence of a rollout plan with timescales for implementation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients who did not have capacity to consent to end of life care were treated appropriately. Records showed that best interest meetings were held with the relevant professionals and suitable involvement of relatives and carers.
- Staff undertook training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of mandatory training.
- We were told the trust resuscitation department carried out an annual audit of ‘do not attempt cardio-pulmonary resuscitation’ (DNA CPR) forms. We requested data from the trust on any audits or review of the DNACPR process in the service but information we received from the trust indicated that the next audit was not due until 2016 following the introduction of a new policy in 2013. The most recent audit provided was from 2012. Whilst we found some monitoring of the completion of DNACPR documentation through the end

End of life care

of life steering committee, there was no clear, effective process for monitoring DNACPR procedures to ensure that patients were identified as end of life appropriately and in line with national guidance.

Are end of life care services caring?

Good



We have rated end of life care services as 'Good' for Caring because;

Specialist palliative care staff interacted with patients in a sensitive, caring and professional manner. Staff were sensitive to the needs of patients who were seriously ill and recognised the impact this had on those close to them. Patients' confidentiality and privacy and dignity were respected and maintained wherever possible. The majority of patients and their families were positive about their experience at MRI. Some relatives told us that sometimes privacy had not been maintained and it was not always possible for a side room to be available. Staff were observed spending time talking with patients and relatives and people were encouraged to be involved in their loved one's care. The specialist palliative care team (SPCT) were committed and enthusiastic about improving end of life care.

The NCDH 2013/14 reported that the trust was slightly above (better than) the England average for access to information relating to death and dying. We spent time with the chaplaincy spiritual care department who confirmed that they could call on spiritual leaders from a number of faiths as necessary to ensure patients' religious wishes were adhered to. The MRI scored 55% in the 2013/14 NCDH for assessment of the spiritual needs of a patient and their nominated relatives or friends. This was better than the England average of 37%.

We asked the trust for further information on any patient/family survey feedback during our inspection. The trust response confirmed that there was no formal mechanism for collating feedback from families and carers about their experience of end of life care in adult patients.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Staff provided reassurance and comfort to relatives who were anxious or worried.
- The majority of patients were happy with the way staff treated them. Other relatives felt that sometimes their loved one had not been treated with as much respect or dignity when the nurses were busy with other patients.
- There were examples of staff treating deceased patients and their relatives with dignity and respect. For example, a pathology technician reminded staff about the need to check if relatives were present before entering the mortuary viewing area.
- Cubicle curtains and doors were closed during consultations to maintain privacy.
- The bereavement team were hospital based and supported families and carers at the time of death. The hospital staff told us they contacted each bereaved family and met with them when they collected the cause of death certificate and their loved one's possessions from the bereavement office.

Understanding and involvement of patients and those close to them

- The trust had introduced 'carer passports' which identified if a relative/friend wanted to be involved in a patient's care.
- Families were encouraged to be involved in care, mouth care and helping people get dressed.
- Training in communication skills was provided through the "Sage and Thyme" programme, a foundation level communication skills workshop developed in response to NICE guidance. The SPCT had attended advanced communications training.
- We asked the trust for further information on any patient/family survey feedback during our inspection. The trust response confirmed that there was no formal mechanism for collating feedback from families and carers about their experience of end of life care in adult patients. The programme of work for the end of life adult steering group included the development of mechanisms to enable consistent feedback from patients, families and their carers in relation to end of life and palliative care.

Emotional support

End of life care

- The SPCT, the chaplaincy, nurse specialists and psychologists provided emotional support to patients and relatives.
- Staff in all ward areas told us they were short staffed at times, which had an impact on providing end of life care, particularly on the time available to give emotional support.
- Two nurses told us they had concerns about the impact of the absence of a replacement for the Liverpool care pathway. They felt that it was difficult to meet patients' spiritual care needs when there was no clear framework.
- Chaplains carried out ward rounds within their respective divisional areas. Referrals to the chaplaincy spiritual centre (CSC) were made by phone, email, letter or personal visit and followed up within 24 hours. Urgent or emergency calls were made through the trust switchboard to the chaplain on call, operating 24 hours a day, 7 days a week.
- The NCDHAH 2013/14 reported that the trust was slightly above (better than) the England average for access to information relating to death and dying.
- We spent time with the chaplaincy spiritual care department who confirmed that they could call on spiritual leaders from a number of faiths as necessary to ensure patients religious wishes were adhered to.
- The hospital scored 55% in the 2013/14 NCDHAH for assessment of the spiritual needs of a patient and their nominated relatives or friends. This was better than the England average of 37%.

Are end of life care services responsive?

Requires improvement



We have rated end of life care services as 'Requires improvement' for Responsive because;

Patients were not always seen by the specialist palliative care team (SPCT) within 24 hours of referral particularly if they were referred at the weekend. The National Care of the Dying Audit of Hospitals (NCDHAH) 2013/14 reported that the trust was below the English average for formal feedback processes regarding bereaved relative /friends of care delivery. Results from an internal audit carried out at the

beginning of 2015 highlighted the need to ensure holistic care assessment and planning, documentation and communication for individuals identified as potentially being in their final hours/days of life.

The month prior to our inspection the trust had started to collect information on people's preferred place of death and other basic data to inform both service planning and monitoring of the care provided. This was in line with national data sets for palliative care.

The trust had a rapid discharge service for discharge to a preferred place of care (PPC). There was open access for relatives to visit patients who were at the end of life, and free car parking for those visiting. Access to side rooms was provided whenever possible.

Service planning and delivery to meet the needs of local people

- The National Care of the Dying Audit of Hospitals (NCDHAH) 2013/14 reported that the trust was below the English average for formal feedback processes regarding bereaved relative /friends of care delivery.
- The trust had a close working partnership with neighbouring hospices. The palliative care consultant also worked at the local hospice which assisted the patient's transition from acute to community/hospice care. We found that there was no hospice provision within inner city Manchester.
- The trust also had representation on the Palliative and End of Life strategic clinical network for the North West. This group plays an active role in formulating policies and guidelines around improving end of life care in the region which would provide support for the SPCT in developing their own service.
- Normal visiting times were waived for relatives of patients who were at the end of their life as well as support with car parking for those visiting.
- There was a viewing room where relatives could spend time with their deceased loved ones in the mortuary.

Meeting people's individual needs

- Ward staff told us where possible end of life patients were nursed in a side room to provide dignity and privacy for them and their loved ones. Staff told us that this was not always possible. There were no identified designated palliative or end of life care beds in the trust.
- When admitted through the emergency department, patients would be identified if they attended with the

End of life care

Limitation of Treatment Order (LOTO) or Do Not Attempt Resuscitation (DNAR) paperwork from home, and this informed the decisions for treatment and where their treatment would occur i.e. home or hospital. Other patients were identified through the clinical decision making process.

- Results from an internal audit carried out at the beginning of 2015 highlighted the need to ensure holistic care assessment and planning, documentation and communication for individuals identified as potentially being in their final hours/days of life. The audit also showed that only 48% of individuals recognised as dying had an individual plan of care based on the five areas considered central to end of life care. The standard expected to be completed was 100%.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- The SPCT outlined how they supported patients with complex needs. They carried out a full holistic assessment on all patients referred to the team.
- Staff had access to a telephone interpreter service for people and carers whose first language was not English. Information gathered when patients were admitted to the ward identified who would need this service and translators were booked when staff needed to explain any treatment or procedures.
- Staff told us they wouldn't use family members to translate for consent which is in line with best practice guidance.
- Information was available for patients throughout the hospital via information leaflets and displayed on noticeboards. Bereavement information booklets 'When someone dies' were available for relatives or loved ones to use with advice on both practical support such as registering the death and where to seek further emotional support.
- The trust had information readily available to alert staff to patients living with dementia who may require more support and time due to their condition.
- The bed management flagging system was utilised at ward level on admission and regularly on a daily basis. The system had a series of trigger questions which prompted staff to ensure that discussions took place regarding the individual needs of the patients and carer and to ensure on-going reasonable adjustment to care planning.

- We noted that patients on the general wards who were at end of life had easy access to call bells. Two patients and their relatives reported that staff were very busy and they sometimes had to wait for the nurses to respond.

Access and flow

- Patients were not always seen within 24 hours of referral to the SPCT particularly if they were referred at the weekend. Data provided by the trust showed that in the three months at the beginning of 2015, 75% of patients were seen within 24 hours of being referred to the SPCT.
- Ward staff had contact details for the SPCT and confirmed the team responded promptly following a referral or when needed for advice by phone if necessary.
- Staff carried out daily meetings to maintain patient flow and to identify and resolve any issues relating to patients at end of life.
- Patients in the last days or hours of life were brought to the attention of the SPCT through the end of life flag on the patient track system. These patients were then reviewed by the SPCT who supported the healthcare professionals in providing individualised care based on the five priorities of care, developed by the national leadership alliance for palliative end of life care.
- The SPCT also undertook regular ward walk rounds to proactively identify patients approaching end of life.
- All wards had access to the rapid discharge team, including members of the palliative care team. The team followed the rapid discharge policy to enable patients to go home after an immediate decision for end of life at home (or in a care home). Information we received from the trust following the inspection showed that out of 180 patient records 57 did not indicate the preferred place of death, 48 indicated that the patient had died at home as part of their last wishes. This did not assure us that the service was able to support patients to access their preferred place of death in a timely manner.
- Furthermore, insufficient data was available from the trust in regards to monitoring of the preferred place of death or percentage of patients discharged within 24 hours. We were told that this was because it was usually carried out in the community.
- Information we received from the trust following the inspection indicated that the SPCT had implemented an electronic system in October 2015 to

End of life care

capture this information in an electronic format. However, to provide the information for the twelve month period prior to the inspection would have required a manual audit of patient notes.

Learning from complaints and concerns

- The trust had a complaints procedure that staff had access to on the trust internet. Staff were able to tell us how they would respond to a complaint on the ward and were able to show us the complaints policy.
- However we were unable to assess the effectiveness of the process for end of life care and any learning as no complaints had been received in relation to the adult's end of life care service.
- Mortuary staff were able to describe how they had responded to complaints from families about the reception area, which involved new furniture and improvements to make the area more user friendly and dignified.

Are end of life care services well-led?

Requires improvement



We have rated end of life care services as 'Requires improvement' for Well-led because;

There was a general governance framework in place for the trust; however there was no trust wide vision or strategy for adult end of life care services. The trust had nominated an executive director to lead adult end of life care services, this was introduced at the time of our inspection. However, the lack of capacity and recent vacancies in senior posts had impacted on the ability of the service to move forward in a timely manner with service improvement and development. Data provided by the trust showed that there was an action plan for end of life care services that had been developed in response to the national care of the dying audit (NCADAH). This identified areas such as patient feedback, training and implementation of a replacement pathway as key actions for the service.

Some of the risks identified on the end of life risk register had not been closed or did not have clear plans in place to mitigate the risks identified, such as the use of syringe drivers. This meant there was no clear overview of the on-going risks within end of life care services or how they were being managed. The trust had identified

improvements were required in the end of life and palliative care service for Manchester Royal Infirmary (MRI). An end of life steering group led by the palliative care consultant had produced a strategic action plan which was being monitored through the group. Although the plan had short term, medium term and long term aims there were no specific target dates set or success performance criteria to assess progress against the plan.

Vision and strategy for this service

- The trust "vision and values" were displayed throughout the hospital. However there was no vision or strategy for end of life care services. Following the National Care of the Dying Audit the trust had produced a strategic action plan to improve areas such as seeking feedback from families and loved ones. However, the lack of an overarching vision or strategy meant that staff working in MRI did not have a clear understanding of what plans were in place for end of life services.
- The delivery of end of life care services was reported in the annual report summary for the trust 2014/15. The report outlined areas where significant work had been undertaken for example in relation to work with commissioners and staff training. The report also defined the trust's commitments in relation to end of life care for 2015/16 although the need to develop a clear strategy for the service was not included.
- We met with the non-executive lead and executive lead for end of life care who confirmed that the trust had started to review end of life care in the past few months and acknowledged there was some improvement to be made to improve service delivery. Following the inspection we received a copy of a draft strategy for end of life care but we found no evidence that this had been discussed with key stakeholders or the end of life steering group.

Governance, risk management and quality measurement

- End of life care services at Manchester Royal Infirmary (MRI) for the purpose of governance reported through the division of medicine and community services.
- Trust managers told us work had been started to review baseline performance in end of life care in the month prior to our inspection. Staff on wards where end of life care was provided measured quality locally including ward accreditation processes and quality performance dashboards.

End of life care

- Some of the risks identified on the end of life risk register had not been closed or did not have clear plans in place to mitigate the risks identified, such as the use of syringe drivers. This meant there was no clear overview of the on-going risks within end of life care services or how they were being managed.
- The trust had an end of end life steering group which covered all aspects of end of life care and reported through a quality committee up to the board. The trust had identified improvements were required in the end of life and palliative care service for Manchester Royal Infirmary (MRI). The group led by the palliative care consultant had produced a strategic action plan which was being monitored through the steering group. Although the plan had short term, medium term and long term aims there were no specific target dates set or success performance criteria to assess progress against the plan.
- There was a robust governance structure in place within the individual clinical speciality units which fed into the trust risk management committee. Monthly governance meetings were held and attended by key professionals. There was an overarching divisional risk register and local risk registers held by each ward.

Leadership of service

- The trust had an identified executive director with responsibility for end of life care, this was introduced at the time of our inspection. However, the lack of capacity and recent vacancies in senior posts had impacted on the ability of the service to move forward with service improvement and development in a timely and effective manner.
- Staff reported that local managers were visible and supportive. Recent changes in leadership roles meant that the trust had initiated a review of end of life care across the whole trust. We met with senior managers who confirmed that the service needed to have clear leaders to act as champions for end of life care services.
- The lead palliative care consultant was seen as a key figure in leading palliative and end of life care throughout MRI but was limited in his capacity to drive the leadership of the service.

Culture within the service

- Staff across the trust valued the work and advice of the SPCT but felt that they were under resourced and not always able to commit time to support staff.
- The SPCT were very passionate about their roles, they were committed to the delivery of end of life care and were actively engaged in improving the training and advice available for staff across MRI and St Mary's Hospital.







Public and staff engagement

- We asked the trust for further information on any patient/family survey feedback during our inspection. The trust response confirmed that there was no formal mechanism for collating feedback from families and carers about their experience of end of life care. The programme of work for the end of life care steering group included the development of mechanisms to enable consistent feedback from patients, families and their carers in relation to end of life and palliative care.
- We saw evidence that the trust had started to work with external partners to establish a bereavement questionnaire/ survey although this was not yet in place.
- Ward staff told us they felt listened to and had access to the intranet which was a useful resource for information.
- Staff told us the trust held monthly "meet the executive team" events when staff could have "tea with the executives".
- The SPCT were positive about their involvement in developing the strategic plan and felt that the recent leadership and management changes were positive in raising the profile of the team and end of life and palliative care across the trust.

Innovation, improvement and sustainability

- The SPCT were keen to engage in research and had been proactive in reviewing the quality of service delivery. The lack of capacity and leadership meant that they had not been able to drive forward key service improvements.
- The increase in activity was not sustainable in the long term and the trust acknowledged the need to review service delivery particularly in light of service reconfiguration across other sister sites.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided at Manchester Royal Infirmary. The main outpatients department and the diagnostic imaging service are located on the ground floor. Between January and December 2014 the hospital saw 365,474 patients, 24% of these were first appointments and 59% were follow up appointments.

The outpatients department provides a range of clinics in areas such as: lipids, cardiology, general medicine, urology, immunology and vascular care. There is also a phlebotomy and diagnostic imaging service.

The diagnostic imaging service provides a comprehensive range of diagnostic and interventional services to patients including ultrasound, computerised tomography (CT), magnetic resonance imaging, interventional procedures, fluoroscopy & contrast imaging, bone mineral densitometry and general radiography. There is also an eight bedded radiology intervention suite for patients undergoing day case treatment. The service performs over 200,000 diagnostic investigations per year by a range of staff including radiologists, radiographers, nurses and clinical support and administration staff. Training for radiologists, radiographers and sonographers also takes place.

Manchester Royal Eye Hospital (MREH) is part of Central Manchester University Hospitals NHS Foundation Trust. The hospital is based on the trust's main site along with the Manchester Royal Infirmary but is a separate, purpose-built building with its own identity as a large, specialist ophthalmic teaching hospital. The hospital provides an ophthalmology emergency and outpatient services

including emergency eye assessment and treatment, post-operative clinical interventions, ophthalmic imaging, ultrasound, macular treatment, cataract treatment, optometry and orthoptics.

We visited the outpatient department and diagnostic imaging services at Manchester Royal Infirmary (MRI) and the Manchester Royal Eye Hospital (MREH) on 4 and 5 November 2015. We also carried out an out-of-hours unannounced visit to MREH on 26 November 2015. At the MRI we observed outpatient clinics for cardiology, liver, and urology. We also visited phlebotomy clinics and radiology services including nuclear medicine. At the MREH, we visited five adult outpatient clinic areas, a paediatric clinic and the emergency eye centre.

During our inspection of these services, we spoke with 19 patients, 1 relative and 44 members of staff including: managers, reception clerks, administration staff, nurses, matrons, junior doctors, doctors, consultants, nursing assistants, a ward manager and the clinical head of division. We observed care and treatment and looked at 16 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Outpatients and diagnostic imaging

Summary of findings

We have rated outpatient and diagnostic services as 'Good' overall because;

Incidents were reported and investigated and action taken to limit recurrence. The areas we visited were visibly clean and tidy. Cleanliness, hygiene and infection control was monitored monthly and results demonstrated compliance. Records were of good quality but were not always available; where records were not available, a system was in place for safe consultation.

Staff were aware of safeguarding processes and knew what to do when they had concerns relating to abuse and neglect. Patient risks were identified and managed with appropriate measures put in place. Nurse staffing was adequate but there were vacancies in radiology due to national shortages of radiologist staff. Actions were in place to manage the shortfalls. Clinics did not operate seven days a week but on call radiology cover was available at all times. Patients received care based on national and local guidance. Audits were undertaken and discussed monthly in multi-disciplinary teams. The nuclear medicine department at the Manchester Royal Infirmary (MRI) used special technology when caring for patients which was available in only two centres in the UK.

We observed staff treating patients with a caring manner and patients described them as kind and courteous. Patients and their carers felt involved in care and that staff explained treatment options in a way they could understand. Key staff acted as leads for care relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. Most patients received appointments within 18 weeks of referral. However, almost a quarter of patients at the MRI waited longer than 60 minutes to be seen once they arrived. The number of patients not attending appointments had improved from 14% to 10% following actions such as text or phone call reminders. At the MRI, diagnostic reports were not always received in a timely way; however staff were aware of the reasons why and had implemented actions to try to address this.

Risk and governance processes were in place. Action plans were monitored to ensure that risks were mitigated. The culture in services was positive and the majority of staff felt valued. There was a strong ethos in ophthalmology services to drive innovation and research to improve patient outcomes experience and improve service provision.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We have rated outpatients and diagnostic imaging services as 'Good' for Safe because;

Incidents were reported, investigated and action taken to limit recurrence. Staff were open and honest in their approach when things went wrong. The areas we visited were visibly clean and tidy. Cleanliness, hygiene and infection control was monitored monthly and results demonstrated staff compliance. Concerns had previously been raised related to staff hand hygiene compliance at the Manchester Royal Eye Hospital (MREH) and significant improvements had been made as part of a targeted hand hygiene programme. Equipment was visibly clean, fit for use, and stored in an organised way. Medicines were stored securely where required. Records were of good quality. However, improvements were required in the availability of records but systems were in place to ensure sufficient information was available for consultation. When full paper records were not available, electronic software allowed staff to create temporary files, ensuring minimal impact to patients.

Staff were aware of safeguarding processes and knew what to do when they had concerns relating to abuse and neglect. Patient risks were identified and managed with appropriate control measures put in place. Nurse staffing was in line with establishment but there were vacancies in radiology due to national shortages of radiologist staff. Actions were in place to manage these shortfalls. Staff were familiar with major incidents and were aware of the process should a major incident be declared.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Staff reported incidents using the trust-wide electronic system which provided email notifications to confirm receipt and outcome of investigations.
- Incidents were analysed and findings were shared at senior level and disseminated to staff in daily, weekly or monthly meetings.

- Incidents relating to radiation were recorded. Between November 2014 and October 2015, 117 incidents were recorded. The majority of these were higher than intended or unnecessary doses of radiation administered.
- Changes occurred as a result of learning. For example, following an incident where scans were placed in the wrong patient record, staff implemented a policy to ensure checks were incorporated into practice.
- Outpatient services at the MREH reported 219 incidents between June and August 2015. The majority of incidents were reported as no harm. All incidents were reviewed by senior staff and findings were acted upon.
- Outpatient services at MREH had specific monitoring arrangements for the use of laser equipment through a designated laser protection advisor. There were no incidents related to laser equipment reported between June and August 2015.
- Outpatient at MREH services had robust monitoring arrangements in place to identify and acted upon themes identified in incident reporting. For example, work had been undertaken which had improved access to patient records, and links had been improved with third party patient transport providers.
- Senior staff were aware of the duty of candour. 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.

Cleanliness, infection control and hygiene

- The services monitored cleanliness, hygiene and infection control knowledge on a monthly basis. Scores between June 2014 and June 2015 showed services were 99% compliant with cleanliness, hygiene and infection control knowledge.
- The Manchester Royal Eye Hospital had an established hand hygiene improvement programme in place following previous poor compliance performance in 2014 with an over-all score of 71%. Results showed that in May 2015, the outpatient services scored 83% and had improved to 100% compliance in June and July.
- The areas we inspected were visibly clean and tidy except for light pull cords in toilets for radiology patients at the MRI which were discoloured.
- Stickers were placed on equipment to indicate it had been cleaned.

Outpatients and diagnostic imaging

- There were approximately 80 rooms in the main outpatient area. The matron said cleaning was done in the morning and after clinics finished. However there were no records of cleaning activity to confirm this. Senior staff confirmed records were not kept due to the large number of rooms.
- Senior staff told us they completed daily visual hand hygiene and room cleanliness checks.
- We observed staff following hand hygiene best practice and 'bare below the elbows' guidance.
- There were ample supplies of hand washing facilities and personal protective equipment such as gloves and aprons.

Environment and equipment

- The outpatient clinic rooms at MREH were well maintained, free from clutter and provided a suitable environment for treating patients.
- We observed that waiting areas in the ophthalmology emergency eye centre and H clinic at MREH did not always have sufficient seating for patients and families. Managers had identified this, and initiatives had been put in place to improve this going forward as part of refurbishment plans.
- The majority of outpatient and radiology areas at the MRI were outdated with small corridors and little natural daylight. However, building work was ongoing to update the environment. The exceptions were the radiology intervention day care suite which had recently been refurbished and the nuclear medicine department. Both these areas were spacious and bright.
- The main reception desk in the outpatient area at the MRI was close to where patients waited and we witnessed conversations between reception staff and patients being overheard by those waiting.
- Equipment was visibly clean and storage was tidy and organised. Items were clearly labelled. Equipment prices were also displayed for staff to raise awareness of costs and limit wastage.
- The trust risk register identified that ophthalmic equipment, for example retinoscopes and ophthalmoscopes were not always immediately available because equipment was required across the service. As a result, plans were in place to purchase additional ophthalmic equipment.
- A resuscitation trolley was kept in the main outpatient area. Items on the trolley were visibly clean and ready for use. Records showed items were checked daily.

- Regulations state that instructions must be visible to keep patients and staff safe in radiology departments. These are known as 'local rules'. Whilst these were present in the required areas, we found some dating back to 2009. The risk manager told us that rules were only updated if changes were required. However minutes from a radiation protection meeting in October 2015 confirmed that some local rules dating back to 2009 required an update.

Medicines

- The trust had a policy for managing the storage, administration, supply and disposal of medicines.
- The outpatient department stored few medicines none of which were controlled drugs. Any medicines were managed by the specialties running clinics.
- An on-site pharmacy also dispensed medicines to patients.
- The outpatient resuscitation trolley in the MRI did contain some medicines. These were in sealed boxes, one for children and one for adults. The seals were in place which demonstrated they were complete and ready for use.
- Radiology staff used controlled drugs. These were stored securely in an alarmed and locked controlled drug cupboard behind digi-locked door. Contrast media (a substance used to enhance the contrast of structures or fluids within the body in medical imaging) was supplied daily.

Records

- Outpatient records were paper based with duplicated electronic copies available on the trust's electronic medical record system.
- Diagnostic images were stored electronically on a picture archiving and communication system (PACS). This enabled image sharing across the trust. At the time of our inspection, there were two separate PACS systems in use across the trust which made sharing information more difficult. However, the systems were due to be merged in December 2015.
- Junior doctors at the MRI said medical notes were available most of the time. However figures provided by the trust showed between 9% and 22% of paper records were not available for clinics in June and July 2015. Staff had a process to follow and created temporary

Outpatients and diagnostic imaging

electronic files when records were not available, which meant the impact to patients was minimal. Senior staff told us this problem would diminish as the medical record system became more established.

- Outpatient clinics at MREH prepared clinic notes in advance to minimise the number of records not available for appointments. We reviewed five clinics being held for the next day and most notes were available. Audits between January and July 2015 showed that between 4% and 7% of patients were seen using temporary notes.
- Whilst this meant that in some cases, up to one quarter of patients were seen in the outpatients department at the MRI without a full set of paper records, the process in place enabled access to relevant information such as test results and medications and was sufficient to mitigate risk.
- We reviewed 16 patient records during our inspection. Each record contained the relevant information including translation requirements, evidence of consent, allergies, correspondence and treatment history.
- Records were audited monthly and action taken to improve issues identified, such as legibility or the inclusion of important information.

Safeguarding

- Staff were trained appropriately in level three safeguarding practice. Although figures for the number of trained outpatient staff at the MRI were not available, trust wide figures showed that by June 2015, 97% of nursing and allied health professional staff had been trained. Records showed 92% of staff across the MREH had completed basic (level one) safeguarding training and 90% of staff had completed advanced (level two) safeguarding training.
- 65% of ophthalmology outpatient staff had received level three training, which was below expected targets. Managers had identified this as an area for improvements and action plans and monitoring arrangements were in place at the time of this inspection.
- The trust had a dedicated children and adult safeguarding team to assist staff and dedicated safeguarding 'champions' worked in departments to provide advice and support to colleagues.

- We saw noticeboards displaying safeguarding information and a matron told us that all staff working in the outpatient department were engaged in safeguarding practices.

Mandatory training

- Staff completed mandatory training annually which covered subjects like infection control, safeguarding and major incidents.
- Records for the MRI showed that 100% of outpatient staff and 85% of diagnostic imaging staff on the radiology intervention site were up to date with mandatory training.
- 87.8% of staff at MREH had completed mandatory training. This showed the majority of staff had completed their mandatory training but compliance was slightly below the trust's internal target of 90%.
- The MREH had recently appointed a designated education lead to support the co-ordination of mandatory training, including reminders for staff to attend training. Staff told us they found this role supportive. Ophthalmology managers told us the number of staff attending mandatory training had increased, and this reflected in the training attendance figures.

Assessing and responding to patient risk

- Guidance was in place for staff should a patient's condition deteriorate whilst under the care of the department. This included a designated contact number for requesting assistance for medical emergencies.
- Resuscitation equipment was available and ready for use in the outpatient department should it be required.
- Patients under the care of nuclear medicine staff were segregated to limit the risk of radiation exposure to others.
- There were 12 laser protection supervisors in ophthalmology services who were available to provide expertise and support to staff related to the use of specialist equipment.

Nursing staffing

- Staffing in the outpatients department at the MRI was done by assigning staff to clinics from within their speciality (for example, surgery, or medicine). Senior staff told us the outpatient service was not understaffed.

Outpatients and diagnostic imaging

- Ophthalmology outpatient staffing levels were planned around clinic capacity and clinical demand, to ensure that there were appropriate numbers of nursing staff to meet the needs of patients.
- We reviewed figures for staffing within different specialties to corroborate this evidence. The staffing vacancy rate in the surgical speciality was 18%, however the use of bank staff brought this rate down to 0.05%. The rate in the specialist medicine speciality was 14% but had been reduced to 6% through the use of bank staff.
- Nurse staffing in the radiology services was generally sufficient. Between September 2014 and July 2015, staffing was almost in line with establishment, with never more than 1.5 staff short from a planned establishment of 12.7 whole time equivalent staff.
- There were no nurse vacancies in ophthalmology outpatient services and nursing staff were used flexibly across the MREH in order to deliver safe care. This minimised the use of bank and agency staff.
- There was evidence of short term staffing pressures in the emergency eye centre due to the unpredictability of the number of patient attendances. In times of peak demand, staff escalation procedures were followed, which deployed staff with the appropriate skills from other ophthalmology areas. This ensured that patients were seen appropriately.

Medical staffing

- There were some medical vacancies in radiology services. These included one in each of the thoracic, vascular and gastro-intestinal specialties and five sonographer vacancies.
- Senior radiology staff explained that workload was increasing annually. This was supported by the Royal College of Radiologists who advised; “the massive growth in applications of radiological imaging and image-guided treatments has resulted in a worldwide shortage of trained radiologists”.
- To address the shortage, sonographers were being trained internally and attempts were made to recruit via a regional training scheme. This had proved successful with three due to begin in February 2016. In the meantime, short falls were covered by locum agency staff.

- There were appropriate arrangements in place for out of hours cover in the emergency eye centre. This had been reviewed following feedback from the General Medical Council. Additional medical cover had been put in place to support junior doctors.

Major incident awareness and training

- Staff were aware of their role in a major incident. The trust had major incident policies and a business continuity plan to help staff.
- The trust used a ‘coordination’ telephone extension number for staff to make contact should a major incident be declared.

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.

Patients received care based on national best practice guidance. Local policies were in place to support staff delivering care. Audits were undertaken and discussed monthly in multi-disciplinary teams. These included audits of IR(ME)R and radiation incidents. There was collaboration with other local organisations to deliver specialist care.

Prescribed pain relief was monitored for efficacy and changed to meet patients’ needs where appropriate. Staff were able to access the information they needed to provide care and treatment to patients. Services were not operating seven days a week but an on call service ensured radiologists were on site for at least five hours each weekend day.

Key staff acted as leads for care relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff used evidence based guidance when caring for patients. For example, pulmonary rehabilitation staff used guidelines from the National Institute for Health and Care Excellence (NICE). Radiologists used the Ottawa Ankle Rules which show areas of tenderness to

Outpatients and diagnostic imaging

be evaluated in patients with ankle trauma to determine need for imaging. Ophthalmology outpatient services followed recognised national guidelines by the Royal College of Ophthalmologists.

- Radiology staff followed the Ionising radiation (medical exposure) regulations 2000 (IR(ME)ER) when administering radiation to patients. 'Local rules' were in place that defined the radiation protection measures in place and were available to staff on the intranet.
- Hospital policies were in place to support staff deliver safe and effective care.
- Updates to policies and guidance were disseminated to staff in monthly meetings.

Pain relief

- Prescribed pain relief was monitored for efficacy and changed to meet patients' needs where appropriate.
- Patients requiring pain relief whilst in the Manchester Royal Infirmary (MRI) outpatients department were directed to a local shop where paracetamol could be purchased.
- Staff at MREH had access to specialist advice from a designated pain team if required.

Patient outcomes

- The services at the MRI participated in a variety of national and local audits with the results shared through presentation. For example a cervical spine trauma audit was conducted in February 2015 to review whether patients with cervical spine injuries received the most appropriate imaging. The results showed that CT scans were often more effective in diagnosing injury than plain film x-ray. Following the audit, recommended actions included developing an algorithm for staff to use when plain film x-rays do not show all the necessary detail.
- An audit to review missed lung cancers on chest radiographs was conducted in July 2015. The results showed that the target to identify more than 7% of cases within one year of diagnosis was met (80%) but the target to recommend further investigation or follow up in 95% of cases was not (83%). Actions following findings included comparing scans and reviewing particular areas of the body, to help identify cases. A further audit was planned to monitor improvement.

- Each speciality completed its own audits and had responsibility for implementing and monitoring action plans to secure improvement when remedial action was required.
- We reviewed the trust's re-audit of risk factors for hepatitis C transmission in HIV positive men in 2015. The audit was clearly documented with a background, method, results, conclusions and an action plan. The results showed improvements from the previous audit in the numbers of hepatitis tests being done, and discussion of risk factors during appointments.
- Audits of IR(ME)R incidents were also completed as well as auditing checks for last menstrual period for female radiology patients.
- The departments contributed to audits for hand hygiene, cleanliness, knowledge of infection prevention practice. All of which indicated good levels of staff compliance with infection prevention and control policies and procedures.
- Outpatient services at MREH had key performance indicators in place, which were in line with national standards and targets.
- MREH had a comprehensive audit programme in place for 2015/16. Monitoring arrangements were in place to review any outstanding actions resulting from clinical audits.
- Audits and outcomes were disseminated to staff from a range of disciplines in monthly meetings.
- The diagnostic imaging service was not participating in the Imaging Services Accreditation Scheme (ISAS) at the time of our inspection. This scheme acts as a mark of quality and takes approximately 18 months to achieve. At the time of our inspection only 23 NHS trusts in the UK were accredited.

Competent staff

- Staff received annual appraisals where performance and development were discussed with a manager. Records showed the majority of staff had received an appraisal in the last 12 months.
- A senior manager in the outpatient team told us that all but two staff were awaiting annual appraisals. Records confirmed this.
- Radiology staff administering radiation were appropriately supervised and trained.
- Appropriate certificates were held by key staff in line with the Administration of Radioactive Substances Advisory Committee (ARSAC) and IR(ME)R 2000.

Outpatients and diagnostic imaging

- There were processes in place to ensure that staff had met the competency requirements to operate equipment safely in ophthalmology outpatient services and diagnostic services.
- Laser safety training, was provided as part of junior doctor's induction, which complied with Medicines and Healthcare products Regulatory Agency (MHRA).
- In MREH advanced nurse practitioners (ANP) and specialist nurses delivered a wide range of nurse led treatments, and were supported by independent clinical advisors who assessed competency as part of an agreed standard. ANP and specialist nurses delivered specialist treatments for example in, ocular plastics, minor eye operations, eye injections, and glaucoma and intravitreal injection service for macular degeneration.
- Imaging technicians ran glaucoma evaluation clinics independently, and technology was used so that doctors were able to view results instantly if a second opinion was required.
- Trainee doctor competency was assessed in MREH by using simulation training. This was introduced following feedback from evaluation from previous medical placements.
- Band three staff were trained to undertake visual field tests and competency was assessed.
- MREH had direct links with universities and offered a range of ophthalmology medical speciality posts and specialist placements for student nurses.

Multidisciplinary working

- There was evidence of multidisciplinary working across outpatient and diagnostic imaging services.
- The outpatient department worked with the local council and disability groups to strengthen the quality of care provided to people with a learning disability.
- Multidisciplinary meetings were held to discuss different topics dependent on speciality. For example, radiologists met with pathology and nursing staff to discuss patients undergoing gastrointestinal investigation. Minutes were taken so that other staff could review them afterwards.
- The radiology department worked with other local NHS Trusts, offering speciality services such as musculoskeletal and vascular interventional imaging.
- In MREH, there were a range of one stop and specialist clinics offered to patients that required

multi-disciplinary working amongst a number of professionals. For example, technician led retinal ocular coherence tomography clinics, uveitis screening, and Goldman pressure testing.

- Ophthalmology services used technology to share ophthalmology images when seeking consultation with medical staff, which supported multi-disciplinary working.
- There was a paediatric trained nurse available in the paediatric clinic at MREH to provide support to young people, however it was unclear what play specialist support was available to support young people's needs.

Seven-day services

- Outpatient and diagnostic services at Manchester Royal Infirmary were not operating full seven-day services at the time of our inspection. Clinics did not take place at weekends. However the radiology service expected to extend services to weekends in April 2016 following the addition of four new staff. It was also expected that once trained, two sonographers would contribute to seven day services completing ultrasound scans for patients with musculoskeletal and abdominal complaints.
- Radiology consultants did operate a seven-day on call service. This required them to be on site for at least five hours each Saturday and Sunday.
- Patients could access the emergency eye centre between the hours of 8am to 8pm. Patients were able to self-refer or be referred by health professionals. Out of these hours, patients requiring assessment were seen at the MRI accident and emergency services.
- Outpatient clinics at MREH were routinely available Monday to Friday; however some clinics ran in the evening and on a Saturday in order to offer a range of appointments for patients.

Access to information

- Picture archiving and communication systems (PACS) were used across the trust to allow access to diagnostic imaging. At the time of our inspection the trust had two of these systems in place due to the merger of existing hospitals into one trust. The systems were due to be merged in December 2015.
- Outpatient staff at the MRI used an electronic medical records system to access patient information. The system stored duplicate records for each patient when paper records were unavailable.

Outpatients and diagnostic imaging

- The majority of staff in MREH outpatient services used paper based patient records supported by an electronic patient records system which ensured staff had access to important information for clinic appointments. Staff said accessing notes was sometimes difficult and this reflected what we saw. The services were in the process of implementing a full electronic patients' record in response to this. Staff evaluations from areas using electronic records demonstrated that this made access to information easier.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Key staff or 'champions' acted as leads for care relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. These staff had additional training to identify patients with additional needs in specific areas.
- Staff understood the requirements around consent and sought consent to provide aspects of care of treatment when required.
- Designated best interest clinics were held each month at MREH for patients and families prior to treatment, to ensure that individual mental capacity was considered and treatment decisions were made using the Mental Capacity Act 2005 framework.

Are outpatient and diagnostic imaging services caring?

Good



We have rated outpatients and diagnostic imaging services as 'Good' for Caring because;

Staff providing care and treatment for patients were positive and compassionate in their approach. We observed staff treating patients with a caring manner and patients told us staff were kind and courteous.

Patients and their carers felt involved in their care and that staff explained treatment options in a way they could understand. The trust regularly asked patients how they felt about the service they received and the majority of patient feedback was positive.

Compassionate care

- The trust used questionnaires to capture the views of patients receiving care. A survey of radiology services confirmed that 92% of patients felt staff had a caring and professional approach to care.
- We observed staff helping patients in the outpatients waiting area with a caring and helpful demeanour.
- We spoke with 13 patients who told us staff had a caring manner and described them as 'kind and courteous'.
- The interventional radiology department asked patients to complete questionnaires about their experience. In July 2015, 100% of patients reported that they were treated with respect and dignity whilst in the department.
- There were arrangements in place to provide patients with a chaperone during appointments that required an intimate examination, or when requested.
- We observed two members of reception staff in the outpatient department at MREH going out of their way to support a patient who needed extra support to access clinics.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Between March and May 2015, 94% to 96% of patients said they were extremely likely to recommend ophthalmology outpatient outpatient services.

Understanding and involvement of patients and those close to them

- Staff responded positively to patients' questions and took time to explain things in a way the patient could understand.
- Staff sought opinions from patients to monitor and improve services. For example, the outpatient colposcopy service distributed 200 questionnaires to patients between October 2014 and March 2015. 92% of patients said they were given adequate advice prior to their appointment, and 84% of patients felt they received the right amount of contact from the hospital to remind them about their appointment (letter, text and phone call).
- A patient survey about the care provided by allied health professional services in 2015 confirmed that 85% of patients felt care and treatment was explained in a way they could understand. 97% of patients felt that staff listened to what they had to say.
- Results from patient experience surveys by the interventional radiology department in July 2015,

Outpatients and diagnostic imaging

showed that 100% of patients reported feeling completely or partially informed about the possible side effects of their procedure. 100% of patients also reported that information was provided in a way they could understand.

- Some patients with glaucoma were taught to self-check their own intra ocular pressures at home using specialist equipment, by a nurse specialist. Information was then uploaded and reviewed by a clinician. This reduced the need for patients to attend the outpatient services and promoted shared care between the patient and staff.

Emotional support

- A survey using the Consultation and Relational Empathy (CARE) measure was completed by cardiac rehabilitation patients in August 2015. Patients reported that staff made them feel at ease, provided them with information and explained things clearly and positively, with care and compassion.
- Staff acted as 'champions' or leads in particular fields such as dementia and alcohol misuse which meant that specialist advice or support was available for patients living with dementia or those affected by alcohol misuse.
- Outpatient services at MREH had access to a range of clinical specialists who were able to provide emotional support to patients. For example, a designated children's eye clinic liaison officer had recently been appointed to support family from diagnosis to discharge.

Are outpatient and diagnostic imaging services responsive?

Good



We have rated outpatient and diagnostic imaging services as 'Good' for Responsive because;

A range of information was available for patients including useful telephone numbers. We found evidence of service re-design that had improved patient flow in ophthalmology outpatient services at MREH. We observed staff assisting patients who raised concerns. Patients raising concerns were dealt with politely and efficiently. Complaints were analysed and disseminated to staff so that change and learning could take place.

The Manchester Royal Infirmary's performance for referral to treatment (RTT) (percentage within 18 weeks) for non-admitted patients was generally in line the expected standard from April 2015 to September 2015 (95.7%). From April 2015 to September 2015, the hospital's average performance for patients with incomplete pathways was better than the expected standard. Across the trust, all three cancer wait measures (patients seen within 2 weeks, 31 day wait and 62 day wait) were generally better than or similar to the England average from 2013/14 to 2014/15. The number of patients not attending appointments had improved from 14% to 10%, following the implementation of key actions such as text or phone call reminders.

However, data provided by the trust showed that from April 2015 to September 2015 9.9% of patients waited over six weeks for a diagnostic test and diagnostic reports were not always received in a timely way. Staff were aware of the reasons for delayed reports and had implemented actions to try to address this. Almost a quarter of patients waited longer than 60 minutes to be seen once they arrived.

Service planning and delivery to meet the needs of local people

- There was a coffee shop situated in the main outpatient area at the Manchester Royal Infirmary and an onsite shop selling a range of magazines and snacks.
- The MREH had recently introduced information stations called "pods" to key information to patients and their families. Patients said they found this useful.
- Information was available for patients covering topics such as carer information, disability rights, and social care information. Telephone numbers for useful organisations such as the Alzheimer's Society were also displayed.
- Patients were asked whether they required translation in advance of their appointment, allowing staff to organise this in good time.
- The nuclear medicine department had designated waiting areas for children and adults.
- Ophthalmology services at MREH had implemented a number of initiatives in order to meet the needs of local people including: a dedicated cataract service at Withington, a new outpatient unit in Altringham, and ophthalmology day surgery at Trafford. There was

Outpatients and diagnostic imaging

evidence of partnership working with commissioners and wider health partners. For example, In 2013/2014 there were over 622 referrals from the Midlands and East England, South England and London commissioners.

- Outpatient appointments for specialist clinics such as optical coherence tomography had expanded to support patients living in Altrincham, Trafford and Withington. It was predicted that this would increase an extra 700 clinic slots.
- Ophthalmology services continually reviewed service planning and were responsive in ensuring that services met the needs of patients. For example, paediatric ophthalmology clinic provision had been reviewed and was part of ongoing work to improve planning and delivery.
- In 2012 staff from the neonatal service and the Manchester Royal Eye Hospital developed a new model of care in which a trained retinopathy of prematurity (RoP) screening nurse undertakes on-site retinal screens using a mobile device (Retcam). The images produced are graded and sent electronically to the ophthalmologist for confirmation. A recent audit of this process demonstrated that the screening nurse produced high quality gradable images of the neonatal retina in 100% of cases. The North West Neonatal Operational Network has asked the trust to replicate this model across the whole conurbation using a peripatetic service. The aim is to prevent infants from being transferred to a specialist centre unnecessarily and to ensure that examinations are undertaken in a safe and timely manner.
- Ophthalmology outpatient services offered “one stop” clinics for patients so that they could receive treatment from a range of specialists on one day. Patients said that this was a good service; however, some patients reported long waiting times in between individual clinic appointments.

Access and flow

- Operational standards are that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. The hospital's performance for referral to treatment (RTT) (percentage within 18 weeks) for non-admitted patients was generally in line the expected standard from April 2015 to September 2015 (95.69%).
- However, this figure did not reflect the variances between the different specialties. The majority of

specialities performed consistently better than the 95% target with some reaching 100% each month (such as clinical oncology and geriatric medicine) but there were instances when some specialities did not meet the 18 week RTT target. For example, the RTT for cardiac surgery was below the expected standard at 85.7%, 82.6% and 87.8% in June, July and August respectively. Urology did not meet the expected standard for August and September (64.4% and 59% respectively).

- From April 2015 to September 2015, the hospital's average performance of 97% for patients with incomplete pathways was better than the expected standard of 92%.
- Between February 2015 and July 2015, the average wait to be seen in ophthalmology services was 3.5 weeks, which was better than the trust average.
- 23% of patients attending appointments waited more than 60 minutes to be seen following arrival in the Manchester Royal Infirmary's outpatient department. General information and current wait time was displayed in the main outpatients department to keep patients informed.
- Across the trust, all three cancer wait measures (patients seen within 2 weeks, 31 day wait and 62 day wait) were generally better than or similar to the England average from 2013/14 to 2014/15.
- 84% of diagnostic reports were completed within 14 days between April and September 2015. Reports not completed within six weeks were marked as breaches. These were analysed and the reason for the breach documented.
- Increased activity in the emergency eye centre had been recognised by the trust and monitoring arrangements were in place as part of escalation procedures. On average, this service saw between 50-100 patients per day. During our visit, we observed escalation procedures in practice, so that additional staff were available to ensure patients received prompt assessment and treatment.
- The emergency eye centre had reviewed times of peak demand and altered medical rotas to support demands in the service. In addition acute referral clinics were led by a principal optometrist who had access to medical staff for advice in the emergency eye centre

Outpatients and diagnostic imaging

- Between April and July 2015, 15 reports for computerised tomography (CT) at Manchester Royal Infirmary breached the six week target. Six of these were due to staffing problems, and the remainder because of equipment malfunction.
- Data provided by the trust showed that from April 2015 to September 2015 9.9% of patients waited over six weeks for a diagnostic test at Manchester Royal Infirmary.
- The radiology department reviewed reporting times for scans every month. The directorate manager confirmed that the time taken to turnaround reports for non-cancer imaging was a concern. Figures for June 2015 showed that only 75% of radiology reports were received within ten working days, and senior managers told us there was a six week back log of report requests for computerised tomography and magnetic resonance imaging. The target for these was 20 working days. Some reports were being outsourced to reduce delays. Between April and September 2015, 1.7%-6.7% of CT scan reports and 22%-39% of magnetic resonance imaging scan reports were outsourced.
- Initiatives such as the introduction of optical coherence tomography machinery at Altrincham mitigated the need for patients to have a second outpatient appointment at the MREH. This improved patient experience and released clinic appointments at the ophthalmology outpatient services.
- 10% of patients did not attend their appointment. Senior staff told us this had reduced from 14% following implementation of actions including sending reminder text messages and telephoning patients to remind them about their appointments.
- Senior staff told us that outpatient clinics were rarely cancelled unless in exceptional circumstances. Figures for June 2015 showed that no radiology clinics were cancelled in the four weeks prior to appointments except in exceptional circumstances, in which case all appointments were rebooked. Exceptional circumstances included consultants being called to attend emergency theatres or short notice staff absence.
- The radiology department reviewed innovative ways to maintain the flow of patients. For example, they were developing a telephone consultation service for designated patients.
- In MREH, there was a patient flagging system in place that identified patients with additional needs, which alerted staff that the patient might need additional support.
- Staff were familiar with patient 'passports'. Passports outline the needs and preferences of patients who are not able to explain this to people easily.
- Staff in outpatient services at MREH had access to specialist teams, for example the learning disability liaison nurse, who provided support to staff and patients as required. The services had a designated dementia champion who supported staff in promoting.
- There were mechanisms in place to provide additional support for patients making decisions about their care and treatment. Good examples were seen in MREH for people living with dementia, learning difficulties and those patients that may lack capacity to make decisions.
- Large chairs and weighing scales suitable for bariatric patients were available in the outpatient area at Manchester Royal Infirmary.
- Translation services were organised on request for patients whose first language was not English.

Learning from complaints and concerns

- We observed staff deal with a verbal complaint in the outpatient waiting area. Action was taken to ensure the patient's issues were addressed promptly and politely.
- Staff gave us examples of action following other complaints such as the introduction of glucose tolerance testing to reduce waiting times and changes to leaflets following negative feedback.
- Details relating to complaints were relayed to staff during monthly departmental meetings.
- Ophthalmology services had been identified as having a high number of complaints and concerns raised. Review identified that most of the complaints related to appointments. A trust transformation project group had been set up to improve processes associated with appointments. At the time of our inspection, there had been a 10% reduction in concerns related to appointments.
- Ophthalmology services used a range of methods for staff to learn from complaints and concerns, including face-to-face, social media, newsletters and safety huddles.

Meeting people's individual needs

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Good



We have rated outpatient and diagnostic imaging services as 'Good' for Well-led because;

Strategies were in place to improve outpatient services. At the Manchester Royal Infirmary (MRI), senior staff were motivated about improving quality and a team was in place to manage this. Actions to improve quality included refurbishment in some areas, the introduction of patient notice boards to improve communication and the creation of 'champions' who, through additional training led in areas such as learning difficulties, safeguarding, domestic abuse, alcohol and the Mental Capacity Act. The services had key standards that were visible for staff. Quality, risk and performance were monitored and discussed at regular meetings and shared with staff. In MREH, there was a clear vision and strategy in place, which considered views from staff, patients and key stakeholders.

Risk and governance processes were in place. Action plans were monitored to ensure that risks were mitigated. There was evidence of a strong ethos in ophthalmology services to drive innovation and research to improve patient outcomes and experience. Staff were passionate about wanting to ensure services were planned in order to meet the needs of the future population in Manchester.

The nuclear medicine department used innovative new technology for assessing coronary artery disease which was available in only two centres in the UK. There was a positive culture across outpatient and diagnostic services. Leaders were visible and the majority of staff felt comfortable with managers.

Vision and strategy for this service

- Strategies were in place in MRI to improve outpatient services. This ongoing project used meetings, action plans and audits to monitor progress. Actions included improvements to the way clinic space was allocated and reduce the rates of patients not attending appointments.
- Clinical radiology staff had a formal five year strategy in place which covered a range of work streams such as

reporting of scan results, and managing increases in demand for services. The strategy included an action plan with a description of each issue, stages to completion, completion dates and mitigation.

- Senior staff were motivated about improving quality and a team was in place to manage this. Actions to improve quality included refurbishment in some areas, the introduction of patient notice boards to improve communication and the creation of 'champions' who, through additional training led in areas such as learning difficulties, safeguarding, domestic abuse, alcohol and the Mental Capacity Act.
- The vision to improve quality was displayed in the main outpatient waiting area and updates about improvement were provided for staff during monthly meetings.
- There was a clear vision and strategy in ophthalmology outpatient services, which considered views from patients, staff and other key stakeholders. The strategy focused on ensuring services would continue to meet increasing demand. For example, by delivering outpatient services on different sites in order to meet the needs of patients.
- Ophthalmology outpatient services had a clear vision regarding developing skills of the multi-disciplinary team to support increased clinical needs and demands on the service. We saw excellent examples in optometry, advanced nursing and specialist nursing initiatives.

Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. There was also a clear pathway for reporting and escalation to the trust board.
- Monthly governance meetings were held with minutes taken and made available for staff. Complaints, incidents, audits and identified risks were discussed at these meetings.
- Outpatient services recorded risks on a local risk register with controls, proposed actions and review dates included. Risks identified at the MRI included potential staffing issues, shortages of equipment and equipment issues. Updates about risk items were provided for staff at monthly team meetings.

Outpatients and diagnostic imaging

- Items on the risk register at MREH aligned with what staff told us, for example, record availability, pressures in clinic A-D and follow up appointments after laser treatment.
- Standard operating procedures were in place to support staff delivering routine and urgent care in diagnostic imaging.

Leadership of service

- Managers were focused on delivering good care and improvement to services was monitored through data analysis.
- The majority of staff reported a positive culture and were comfortable with managers. However, some phlebotomy staff at the MRI felt managers were not always as visible as they would like.
- Leadership within the ophthalmology outpatient service was supportive, pro-active and used a collaborative approach to driving improvements in the quality of care provided.
- Schemes such as the employee of the month and “brilliant basics” celebrated staff achievement and promoted the values of the organisation.

Culture within the service

- Departments were positive about providing good care and staff were proud of their work.
- Senior staff described a ‘can do’ culture in the radiology department.
- The vascular access service provided by the interventional radiology team at Manchester Royal Infirmary was named the 2014 North West Radiography Team of the Year by The Society of Radiographers.
- In one of the focus groups held during our inspection, staff described feeling intimidated when requesting urgent ultrasound scans. This resulted in avoidance of the department which they said impacted on patient care.
- Phlebotomy staff at the MRI reported feeling anxious about making mistakes at work following the suspension of two staff. We raised this with the outpatients matron who explained that a new governance system had been introduced which restricted practice under some circumstances until investigations were complete. Staff were then re-introduced to full duty following supervision. Given the potential impact of some mistakes, the manager felt that restriction was appropriate in these circumstances.

- There was an open and honest culture in ophthalmology outpatient services. It was evident that staff were proud of the service they provided. Staff were encouraged to be involved in improving services.
- Staff felt valued and respected, and were committed to supporting patients and each other to deliver services. We observed that staff in the emergency eye centre regularly stayed after their duty finished, so that they could ensure that patients were discharged from the centre safely.

Public engagement

- A survey about allied health professionals in June 2015 showed that 100% of patients felt they had enough privacy and that staff were clean, smart and friendly, 85% of patients felt that staff explained care and treatment in a way they could understand, and 97% of patients felt that staff listened to what they had to say.
- The outpatient department at the MRI displayed patient suggestions for improving services and survey outcomes. The results were displayed on noticeboards in the main waiting area.
- Other noticeboards showed topics relevant to patients such as dementia care.
- The radiology service used patient satisfaction surveys to measure people’s opinions about services. These were discussed twice a month at team meetings. Minutes were produced and shared with staff on the departmental website.
- We saw good examples of action taken following feedback from patients in ophthalmology outpatient services. For example, initiatives to improve links with external transport provision, improvement of specific information displays called “Hot pockets” and the development of a young person strategy to ensure that children’s views were collected and acted upon. This had resulted in a quality of care action plan being put in place to improve the delivery of children services in ophthalmology.

Staff engagement

- A noticeboard in the outpatients area at the MRI presented information for staff called ‘celebration of success’. Information about nominating colleagues for awards, and compliments received were displayed.
- The radiology department developed a staff website to increase the knowledge of ward staff.

Outpatients and diagnostic imaging

- Staff in ophthalmology outpatient services said they were actively engaged in shaping services. We saw evidence of staff engagement in work undertaken in the “atrium group” which focused on improving patient services in the services.
- Staff had identified though the “make one change” initiative that improvements were needed to make H clinic at MREH more child friendly. Following staff engagement, an improvement plan was put in place.

Innovation, improvement and sustainability

- The nuclear medicine department used innovative new technology for assessing coronary artery disease which was available in only 2 centres in the UK. This meant that patients only required a single one hour visit rather than two visits and three hour appointments. It also meant lower radiation doses were administered to both staff and patient when compared with conventional technology.
- In 2014 the trust initiated a project to improve outpatient care. Divisions assessed their departments using twelve standards such as, being caring and professional in the delivery of care and, a target to see patients within 30 minutes. Patient experience questionnaires were also incorporated. Following this, key objectives were identified. These included implementing a room availability system and having dedicated volunteers in outpatient departments, which we saw during our inspection. The project was on going with plans for further self-assessments in January 2016, and divisional implementation following the launch of key standards in February 2016.
- There was evidence of a strong ethos in ophthalmology services to drive innovation and research to improve patient outcomes and experience. Staff were passionate in wanting to continually improve services, to ensure that services were planned in order to meet the needs of the future population in Manchester.
- We saw good examples of staff sharing research learning and receiving recognition outside the trust, for example genetic testing for paediatric cataract conditions and the treatment of amblyopia in children.
- Ophthalmology staff were proactive in seeking ways to use technology to improve the quality of care delivered. For example, trained nurses were able to undertake eye screening for retinopathy of prematurity (ROP) using a web cam for babies in the neo-natal unit and were able to get immediate clinical review by ophthalmology consultants. The service had been evaluated as successful and was provided in other units as a result.

Outstanding practice and areas for improvement

Outstanding practice

- Staff monitored patients by using an electronic early warning score system that automatically notified medical staff if there was deterioration in a patient's medical condition. This process was fully embedded across the main site and all the staff we spoke with were positive about using this system.
- The nuclear medicine department used innovative new technology for assessing coronary artery disease which was available in only 2 centres in the UK. This meant that patients only required a single one hour visit rather than two visits and three hour appointments. It also meant lower radiation doses were administered to both staff and patient when compared with conventional technology.
- The neonatal unit used video technology to support women who were not well enough to visit their baby, and a bleep system for parents so that they were involved when decisions were being made by medical teams.
- The gynaecology emergency unit was locally unique in that it allowed patients to refer themselves to a specific unit for assessment and treatment of gynaecological emergencies and problems in early pregnancy.
- The development of a nationally unique service relating to developmental sexual dysfunction. This specialist clinic met the very specific needs of patients suffering a variety of sexual development issues. Patients who attended this clinic had the opportunity to be seen by consultant gynaecologists, endocrinologists and psychologists. Counselling services specific to the patients who attended the clinic was also available.
- Staff at St Mary's hospital participated in an extensive programme of local, national and internationally recognised research. In areas such as female genital mutilation (FGM), senior staff within St Marys were participating in the development and implementation of national guidelines.
- The adult rheumatology ward had really thought about the feelings of young people transitioning into their department. They considered how young people would feel sitting in waiting rooms predominately designed for older patients and had developed a separate young person clinic, which was due to start in January 2016. They had involved young people in the re-design of the waiting room, using a mural of photographs of the young patients. The ward had set up a youth group who communicated via social media, which the staff monitored. They had developed their own education sessions for young people, in particular a session called 'Sex, drugs, rock and roll', to inform the young people of their condition and the impact of their life style choices.
- The baby hip clinic was the first example of a one stop assessment and treatment service for children with developmental dysplasia of the hip to be a collaboration between all consultants, rotating through the clinic, with agreed protocols and pathways, allowing standardisation of care and facilitating audit and research. This innovation placed the clinical needs of children and ease of accessing assessment and treatment for parents at the forefront of service redesign.
- Trained nurses were able to undertake eye screening for retinopathy of prematurity (ROP) using a web cam for babies in the neo-natal unit and were able to get immediate clinical review by ophthalmology consultants. The service had been evaluated as successful and was provided in other units as a result.
- The MREH was identified as a NICE exemplar (best practice) service for the management of glaucoma.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed

Outstanding practice and areas for improvement

in all services, particularly urgent and emergency services, medical care, surgery services and end of life care. This also includes midwives in all areas of the maternity services and sufficient doctors to provide timely review of patients when requested.

- Improve patient flow through the Manchester Royal Infirmary, St Mary's Hospital and Royal Manchester Children's Hospital, particularly in maternity services, medical care, surgery services and A&E.

Action the hospital SHOULD take to improve

- Ensure checks of resuscitation equipment are carried out and recorded in line with trust policy and procedures.
- Ensure medicine fridge temperatures are recorded daily and staff take appropriate action if and when a temperature is outside the recommended range.
- Continue to improve the quality and storage of patient records to ensure they are fully completed and all contents are securely stored.
- Ensure that all staff receive appraisals and mandatory training to enable them to carry out their role and responsibilities.
- Have a vision and strategy in place for end of life care for adults, children and young people. The trust should review the leadership for palliative care across the service to ensure it reflects the needs of patients.
- The trust should ensure that appropriate systems are in place to assess, monitor and improve the quality of end of life care provision for patients and their families.

In urgent & emergency services

- Upgrade the mental health rooms as planned.
- Ensure that there are established systems in place to effectively document adult safeguarding concerns.
- Ensure the risk register is regularly updated and clearly reflects actions taken to control and mitigate risks.
- Consider how to prevent or manage the spread of infection on OMU.
- Consider how side rooms without nurse call bells are used in ED.
- Consider how to make services in the WIC more child friendly.
- Ensure staff in the children's emergency department hand hygiene protocols to prevent the spread of infections.
- Review safeguarding processes for triaging a patient and the electronic patient record system to ensure

that every opportunity is taken to identify and make staff aware of safeguarding or child protection concerns when a child or young person presents at the children's emergency department or walk in centre.

In medical care services

- Consider the review of training around the the medicines policy in relation to the administration of patients own medication and the administration of when required medication.
- Ensure that all staff understand and follow the correct process when completing DoLS applications.
- Ensure that all equipment has up to date electrical safety certificates and that oxygen cylinders are stored in line with guidelines.
- Ensure that patients' privacy and dignity is maintained at all times on the endoscopy unit.
- Ensure that all staff seek consent for the use of bedrails and if patients lack capacity apply the Mental Capacity Act (2005) principles.

In surgery services

- Improve availability of patient notes for patients admitted as part of the rapid access process.

In critical care services

- Should review the medical staffing model operated in the paediatric high dependency unit (PHDU) to ensure that it fully supports effective care for children on the unit.
- Should ensure there is a clear vision and strategic plan in place for the cardiac intensive care unit.

In maternity and gynaecology services

- Ensure that all areas of the maternity services are clean and tidy at all times.
- Ensure that personal protective clothing used in the operating theatres meets with current guidance.
- Ensure there is adequate seating made available for patients to wait in comfort in the day assessment unit and the maternity triage area.
- Ensure their policy and procedures for the induction of labour meet with current guidance.
- Take action to ensure that there is a robust system for protecting babies from abduction.

In children and young people's services

Outstanding practice and areas for improvement

- Ensure there is a clear policy in place for transition services based on current guidelines and relevant legislation that considers how services can work in a joined up way to provide a person centred approach across children and adult services.
- Ensure medicines are labelled with the date they are opened so that they are disposed of in a timely manner.
- Consider having a designated isolation area, for patients that enter the children's emergency department with infectious diseases.
- Consider how blood sample tubes can be transported from ward 85 to the pathology laboratory in a timely manner.
- Continue to work with children, young people and their families to ensure that food and menu options are child friendly and appeal to patients using the service.

In end of life care services

- Ensure staff have access to suitable and sufficient equipment, such as syringe drivers to deliver person centred care in a safe and effective way to meet people's needs.
- Review its access to specialist palliative care over 24 hours (seven days) in line with national guidance for end of life care.
- Ensure that it fully implements the national recommendations following the removal of the Liverpool Care Pathway.

In outpatients and diagnostic imaging services

- Reduce the frequency of delays above 60 minutes for patients attending appointments.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed in all services. This is because there was a shortage of nursing staff in urgent and emergency services, medical care and surgery services. There was a shortage of midwives in all areas of the maternity services and insufficient doctors to provide timely review of maternity patients when requested. There was limited access to specialist palliative care consultant support.</p> <p>Regulation 18 (1) and (2), HSCA 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Care and treatment was not always provided in a way that met the needs of patients.</p> <p>This is because action was required to Improve patient flow through the Manchester Royal Infirmary, St Mary's Hospital and Royal Manchester Children's Hospital in response to increased demand on the services provided, particularly in maternity services and critical care. There was no clear strategy in place for end of life care and transition services.</p> <p>Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2014</p>