The Pennine Acute Hospitals NHS Trust

Rochdale Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

Rochdale Infirmary is part of The Pennine Acute Trust and the trust has three other acute hospital sites, which are: North Manchester General Hospital, Oldham General Hospital and Fairfield Hospital (Bury), and also provides a large community service.

We were told that 13,100 patients had attended the day surgery unit from July 2014 to June 2015.

During our inspection, we visited five theatres, two recovery wards and the ophthalmic ward

The Care Quality Commission (CQC) carried out a comprehensive planned inspection at Rochdale Infirmary between 23 February and 3 March 2016; we inspected urgent care, medical, surgical and outpatient and diagnostic services. There are 21 inpatient beds at the hospital.

The urgent care centre provides non-emergency services to around 240,000 residents that live in the communities of Heywood, Middleton and Rochdale. The department is open 24 hours a day, seven days a week.

Medical services at Rochdale Infirmary are provided from two wards and an endoscopy department. The clinical assessment unit (CAU) accepts patients via GP referral, or patients may be admitted via transfer from other trust sites or the urgent care centre. Rochdale Infirmary also hosts the oasis unit, which is a five bedded specialist dementia ward, offering medical treatment to patients with a diagnosis of dementia or delirium.

The surgical services at Rochdale Infirmary carry out a range of surgical procedures such as ophthalmology, colorectal surgery and general surgery (such as gastro-intestinal surgery. 13,100 patients attended the day surgery unit from July 2014 to June 2015.

The outpatient department (OPD) provides a number of clinics, including orthopaedic, urology, rheumatology, pain, respiratory and infectious diseases. The radiology department provides digital radiography services, computed tomography (CT) and magnetic resonance (MR) imaging.

The overall rating for this hospital was good for medical care, surgery and outpatients and diagnostic services, however, urgent care services required improvement.

Our key findings were as follows:

Incident Reporting

- Staff were encouraged to report incidents, which included near misses. Feedback was optional but staff reported that feedback was given when asked for.
- We saw evidence of incidents being reviewed by the clinical lead in the department and actions being taken so that lessons were learnt. If a serious incident occurred, the trust policy was for it to be escalated to the risk management team who would then assign it to an appropriate member of staff for investigation.
- Patients were given information about how to make a complaint. There had been four complaints about medical services at the hospital between 1 December 2014 and 31 December 2015. Complaints were discussed at clinical governance meetings and a quarterly learning from experience was sent to the trust board.
- However, complaints and concerns were not responded to in a timely manner to help improve services within the urgent care department.

Summary of findings

Cleanliness and infection control

- Medical services were clean and tidy. Infection prevention audits were completed and showed that the areas we visited were compliant with trust policies. We saw staff using personal protective equipment, such as aprons and gloves and observed them washing their hands appropriately.
- In surgical services we observed good infection prevention practices by staff and noted good compliance in this area.

Caring

- Staff were kind, caring and compassionate. They maintained the privacy and dignity of patients in their care.
- Patients were cared for in an individualised way of the oasis unit and their carers and families were encouraged to be involved in their care.
- Friends and family test results showed that 97.5% of patients would recommend medical services at Rochdale Infirmary. Open visiting was in place and there was access to specialist mental health services.

Leadership, vision and clinical governance

- Overall the hospital leadership was strong and cohesive, with a clear vision and strategy.
- Care and treatment was delivered in line with evidence based practice and national guidance, such as those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM).
- Local audits were completed and the endoscopy unit was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- Staff described the culture as friendly and supportive and they were proud of the services they provided; staff were positive about working in the service and described a culture of flexibility and commitment.
- Staff had been involved in the development of the trust vision and values and the “healthy, happy, here” programme of work.
- However, Patient risk was not always monitored and documented appropriately through the use of the early warning scores (EWS) and the Manchester early warning score (MANCHEWS) for children in the urgent care department.
- The effectiveness of treatment was not measured on a regular basis so that there was the opportunity to improve services within the urgent care department.
- Patient records were not consistently recorded in line with GMC guidelines within the medical department and not always kept securely in the surgical department.

Staffing

- Medical and nursing staffing levels and skill mix in surgical services was recognised as being appropriate to meet patient need and reflected current guidance. Operating theatres were established against the ‘Association for Perioperative Practice (AfPP) staffing recommendations.
- In medical services, nursing staffing had been calculated using a recognised acuity tool and shift fill rates were very high. Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital.
- However, there were not always sufficient numbers of staff with the appropriate skills available in the urgent care department at all times.

Providing responsive services

- The hospital was generally responsive to people’s needs and the oasis unit within the medicine department is was an example of outstanding innovation and service planning and met meets both the needs of the local population and individual needs; the oasis unit was designed to be dementia friendly. The unit reflected the needs of patients living with dementia and staff delivered patient-centred care. There was a trust wide dementia strategy and a nurse consultant in dementia care.
- Ambulatory care was available seven days a week, reducing the need for patients to be admitted to hospital.
- Patients with a learning disability were identified and there was a learning disability specialist nurse.

Summary of findings

- Pain was assessed and patients received timely pain relief. Patients had their nutritional needs assessed.
- Feedback from staff and patients had resulted in changes to aspects within the service.

Access and flow

- The urgent care & emergency services department had performed consistently well in achieving the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours.
- Referral to treatment times (RTT) and cancer waiting times were better than the England average, clinicians engaged with appointment booking staff to meet targets around RTT.
- There were clear admission and discharge processes in place and a transfer of care team was available to support with more complex discharges.
- In medical services, the average length of stay was lower (better) than the England average and the overall risk of readmission was also lower.
- In surgical services, service developments had improved patient access to treatment through the introduction of new elective lists.
- However, the did not attend (DNA) for appointment rates in the outpatient department (OPD) were higher than the England average and DNA rates were also high in the radiology department.

We saw several areas of outstanding practice including:

- The oasis unit was an example of outstanding innovation and service planning to meet both the needs of the local population and individual needs. The unit opened in 2014 and was thought to be the first of its kind in a hospital in England at this time. This unit offered specialist care for patients with delirium or living with dementia during periods of acute illness. The unit was designed to be dementia friendly and offered patient-centred care. The positive impact of the unit had been recognised and was doubling in size as a result of this.
- The Outpatient and Diagnostics department had a patient tracking list that was clinically led.
- The radiology department had no backlog in reporting in any modalities; this had been recognised nationally as extremely good practice.

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

Action the hospital MUST take to improve:

Urgent care

- The department must ensure that there are sufficient numbers of staff with the appropriate skills available at all times. This includes ensuring that there are sufficient numbers of staff available to resuscitate adults and children.
- The department must ensure that staff have Advanced Life Support training.
- The department must ensure that patient risk is monitored and documented appropriately through the use of the early warning scores (EWS) and the Manchester early warning score (MANCHEWS) for children.
- The department must ensure that the effectiveness of treatment is measured on a regular basis so that there is the opportunity to improve services when required.

Action the hospital SHOULD take to improve

Urgent Care

- The department should improve performance in relation to triage times.
- The department should ensure that they provide appropriate documentation and training to support staff when providing care to patients whose circumstances make them vulnerable, such as those living with dementia or a learning disability.
- The department should ensure that all equipment is checked on a regular basis and that it is safe for use.

Summary of findings

- The department should ensure that fridge thermometers are working in a way that ensures that medication is kept in an appropriate environment and these should be recorded daily.
- The department should continuously monitor the service that they provide through local audits and audits that are recommended by the royal college of emergency medicine (RCEM). This should include developing action plans to facilitate improvement.
- The department should facilitate all planned training days so that staff can maintain and develop their skills.
- The department should ensure that complaints and concerns are responded to in a timely manner.

Medicine

- The department should ensure that records are completed and maintained in line with General Medical Council (GMC) guidance on keeping records and CG2 - record keeping guidelines.
- The department should carry out a risk assessment of the environment manometry room with specific consideration of infection control, accessibility, storage of equipment and supplies and privacy and dignity.
- The department should ensure that there is a system in place to deploy sufficient numbers of suitably qualified, competent and skilled staff on the oasis unit to maintain the safety of all patients, regardless of the presence of staff employed by other trusts.
- The department should ensure that staff receive a regular and effective appraisal to enable staff to carry out the duties they are employed to perform.
- The department should consider undertaking local patient surveys to gain feedback from the public about services provided.

Surgery

- The department should consider the provision of additional training for staff in relation to the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- The department should develop surgical strategies as part of the 'Healthier Together' strategy.
- The department should ensure that access to clinical waste is restricted to designated staff groups.
- The department should ensure that patient records are secure at all times.

Outpatients and diagnostics

- The department should continue to reduce the waiting times for the diagnostic procedures of colonoscopy, gastroscopy and sigmoidoscopy.
- The department should consider the replacement of the allied health professional senior manager for the trust.
- The department should reduce their did not attend rates in the outpatient department (OPD) and in radiology.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	**Requires improvement** 	• Overall we judged the department as 'requires improvement', because: • The department was not always able to achieve the correct number or the right skill mix of staff to meet patient need. • The department was not always able to ensure that staff with up to date training in resuscitation were provided. • Performance against the Royal College of Emergency Medicine (CEM) standard of patients being triaged within 15 minutes of arrival was poor. • There was limited measurement of the effectiveness of the treatment provided. However, : • The department had a clear vision and strategy which was part of the divisional five year forward plan. • The department had performed consistently well in achieving the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours. • Care and treatment was delivered in line with evidence based practice and national guidance, such as those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM).
Medical care (including older people's care)	**Good** 	We judged the service as good because: • Incidents were reported and learning was shared via a monthly newsletter. Harm free care was monitored and measured monthly and the wards we visited had a good track record on safety. • Medical services were clean and tidy. We saw staff using personal protective equipment, such as aprons and gloves and observed them washing their hands appropriately.

Summary of findings

- Staff were aware of their responsibilities in relation to safeguarding. Safeguarding children and adults level two had been completed by 93% of staff.
- There were systems in place to ensure that patients were assessed and risks were monitored and minimised.
- Nursing staffing had been calculated using a recognised acuity tool and shift fill rates were very high. Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital..
- Care and treatment was delivered in line with national guidance and best practice.
- Pain was assessed and patients received timely pain relief. Patients had their nutritional needs assessed.
- Staff were supported to develop their skills.
- Staff were kind, caring and compassionate. They maintained the privacy and dignity of patients in their care.
- Patients were cared for in an individualised way of the oasis unit and their carers and families were encouraged to be involved in their care.
- Friends and family test results showed that 97.5% of patients would recommend medical services at Rochdale Infirmary.
- Services had been planned to meet the needs of local people, Ambulatory care was available seven days a week, reducing the need for patients to be admitted to hospital.
- Referral to treatment times for the trust for admitted (adjusted) patients were above (better than) the England indicator and England average.
- The specialist oasis unit was thought to be the first of its kind in a hospital in England. This type of unit is an example of outstanding practice.
- There were clear admission and discharge processes in place and a transfer of care team was available to support with more complex discharges.
- Patients were given information about how to make a complaint.
- Staff were aware of the trust vision and values. Staff had been involved in the development of

Summary of findings

the trust vision and values and the "healthy, happy, here" programme of work. There was a service improvement plan in place for the division of integrated community services.

- The risk register was up to date and detailed actions taken to reduce identified risks.
- Leaders were visible and staff felt supported by them.
- Staff described the culture as friendly and supportive and they were proud of the services they provided.
- Leaders were supported to be innovative in the way they worked and were able to give examples of changes they made to improve services for patients such as an onsite blood laboratory and an onsite doppler service.

However,

- Infection control training rates fell below the trust target, particularly for staff with patient contact roles.
- The manometry room was not fit for purpose and required improvements to be made.
- . The approach to documentation in records was not consistent between staff.
- Nursing staffing numbers on the oasis unit did not take account of when mental health nurses were not available.
- Performance on the national heart failure audit was poor in comparison the England average
- There was access to diagnostic testing, but if this was required out of hours or at weekends, then patients were transported to other sites within the trust.
- Bed occupancy rates were high at around 93% and there was sometimes a waiting list to access the oasis unit.
- Although there were open and honest care boards detailing actions taken from patient feedback, there had been no local patient surveys carried out recently.

Surgery

Good

Surgical services were judged as good because.

- Systems were in place to ensure incidents were reported, investigated and lessons learnt.

Summary of findings

- Patient's risks were assessed to determine their fitness for surgery. Only lower risk patients were identified to proceed with surgical treatment at this hospital site.
- We observed good infection prevention practices by staff and noted good compliance in this area.
- We observed high levels of staff attendance at training sessions, 100% of day surgery nursing staff had completed mandatory training.
- Consent processes were generally robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Medical and nursing staffing levels and skill mix was recognised as being safe and reflected current guidance.
- There was good access and flow within the service and people's needs were being met.
- Patients received evidenced based care and treatment and patient outcomes were good.
- Good multi-disciplinary working existed between the trust, surgical day service, local clinical commissioning group and community services.
- Staff were caring, compassionate and respectful. Staff were positive about working in the service and described a culture of flexibility and commitment.
- The service was well led and a clear leadership structure was in place. Individual management of the different areas were well led.

However

- **Patient records on the day surgery unit were observed to be in an open top records trolley, which did not ensure their security.**
- **Discussions with some staff showed that they did not understand the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards, which could affect the support they provided to patient groups.**

Summary of findings

Outpatients and diagnostic imaging

Good

We judged the outpatient and radiology services as good .

- Mandatory training levels were good and the environment was visibly clean and tidy. Equipment was checked regularly and there was evidence to support this. Staff knew how to report incidents and this was followed up through regular staff meetings.
- Staff were using national guidelines which were being reviewed for compliance by the trust.
- There were good opportunities for staff development and there was evidence of good relationships between doctors and nurses and effective multi-disciplinary team working.
- Referral to treatment times (RTT) and cancer waiting times were better than the England average, clinicians engaged with appointment booking staff to meet targets around RTT.
- Leadership was effective in the OPD but not as good in the radiology department where there had been some recent changes in the management arrangements.

However

- The did not attend (DNA) for appointment rates in OPD were higher than the England average and the trust did not have anything in place to address this.
- DNA rates were also high in the radiology department.
- There were issues around the storage of medicines , the trust was working to change this with pharmacy colleagues.

Rochdale Infirmary

Detailed findings

Services we looked at
Urgent Care services; Medical care (including older people's care); Surgery; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Rochdale Infirmary

Rochdale Infirmary is in Rochdale a large town in Greater Manchester. Rochdale Infirmary is part of The Pennine Acute Hospitals NHS Trust . There are approximately 21 inpatient beds on the site

The hospital hosts an Urgent care service which treats approximately 56,692 patients a year.

Medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology.

The surgical services at Rochdale Infirmary carry out a range of surgical procedures such as ophthalmology, colorectal surgery and general surgery (such as gastro-intestinal surgery).

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

Our inspection team

Our inspection team for the Trust was led by:

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

Head of Hospital Inspections: Ann Ford, Care Quality Commission

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

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 Rochdale Infirmary and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

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

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

We undertook an unannounced inspection between 4pm and 9.30pm on 17 March 2015. During the unannounced inspection we looked at the management and staffing in the Urgent care department.

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

Facts and data about Rochdale Infirmary

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

In 2014/15 (the trust had 117,656 inpatient admissions) the hospital had 142,970 outpatient attendances and 52,692 patients attended the urgent care centre from the communities. 1 baby was born at the hospital. In total the hospital has 21 beds.

The health of people in Rochdale is generally worse than the England average. Deprivation is higher than average and about 25.2% (11,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Rochdale is ranked 17th most deprived local authority (out of 326) and is in the most deprived quintile.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

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

The Urgent Care Centre was run by the Division of Community and Integrated Care Services within the trust. The department provided non-emergency services to around 240,000 residents that live in the communities of Heywood, Middleton and Rochdale. The department was open 24 hours a day, 7 days a week.

The department had separate waiting areas for adults and children. In the main area of the department there were four designated paediatric cubicles, two distraction rooms which had toys, books and a television, a plaster room and a room that was used for ophthalmology. There were seven cubicles available for assessing and treating adults which included three doored cubicles and there was a resuscitation cubicle which had appropriate resuscitation equipment.

A designated room was provided for the assessment and treatment of those people with mental health complaints. The department was supported 24 hours a day by the rapid, assessment, interface and discharge team (RAID),

There was access to x-ray facilities between the hours of 8.30am and midnight 7 days a week and there was an ophthalmology service which saw patients within normal working hours, however there was 24 hour on call access if needed. There was also access to general practitioner (GP) services within the department.

As part of the inspection we spoke to patients and relatives, we observed the daily practice of staff providing care and treatment to patients, and reviewed patient records.

We also spoke with a range of staff from various grades including managers, nurses, doctors and consultants.

Prior to, and following the inspection we reviewed further information provided by the trust.

Urgent and emergency services

Summary of findings

Overall we rated the department as 'requires improvement', however we found caring, responsive and well led to be 'good' because:

- The department were not always able to achieve correct number or the right skill mix of staff to keep patients safe. There was a heavy reliance on bank and agency nursing staff and locum doctors.
- We found that although mandatory training compliance was generally good, the department were not always able to ensure that staff were up to date with required resuscitation training.
- Performance against the Royal College of Emergency Medicine (CEM) standard of patients being triaged within 15 minutes of arrival was poor. We also saw that early warning scores were not documented as per trust policy. This was important as it allowed recognition of a deteriorating patient.
- There was limited measurement of the effectiveness of the treatment provided which limited the opportunity for lessons to be learned or improvements to be made.

However,

- The department had a clear vision and strategy which was part of the divisional five year forward plan. The focus was for the services provided to be GP, doctor and nurse led. We found that there was a positive culture amongst staff and we were told that they felt respected and supported by the management team. There was evidence of their being positive links with external stakeholders such as care commissioning groups.
- The department had performed consistently well in achieving the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours.
- The management team had taken the needs of the local population into consideration when developing services that were provided. This included services for children such as a separate waiting area and distraction cubicles that were used when waiting for treatment.

There was evidence of patients being treated compassionately and having their privacy and dignity respected.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

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

- We saw that on a number of occasions the department failed to provide the total number of staff that was planned or provide the level of skill mix that was required. This included some occasions when the department could not provide emergency nurse practitioner cover which meant that there was not always the correct level of staff to see, treat and discharge patients.
- The department relied heavily on locum doctors. However, they tried to use the same staff on a regular basis so that they were familiar with protocols and procedures.
- There were low levels of nursing staff that had completed advanced paediatric life support, immediate life support training for adults and advanced adult life support.
- There were several pieces of equipment that had not been portable appliance tested (PAT) at the time of the inspection.
- Records indicated that there were some occasions when the adult and paediatric resuscitation trolleys had not been checked as required. There was no record that these occasions had been reported as an incident at the time of the inspection.
- A review of records highlighted that staff had failed to complete and document early warning scores for both adults and children on seven out of ten occasions.

However;

- Records were generally clear, legible and up to date.
- There was a robust safeguarding process in place which included regular peer reviews. Staff were able to give examples of safeguarding concerns and what actions they would take if a concern was identified.
- Infection control was generally well managed and staff had regard to trust policy and best practice guidance.
- There was generally high compliance with mandatory training overall.

Incidents

- Incidents were recorded and documented using an electronic incident reporting system. Staff were clear on its use and could identify the types of incidents that should be recorded and could clearly demonstrate how to use the system.
- There was a trust-wide policy in relation to incident reporting that was available on the intranet and staff knew how to locate it.
- Staff were encouraged to report incidents, which included near misses. Feedback was optional but staff reported that feedback was given when asked for.
- We saw evidence of incidents being reviewed by the clinical lead in the department and actions being taken so that lessons were learnt. If a serious incident occurred, the trust policy was for it to be escalated to the risk management team who would then assign it to an appropriate member of staff for investigation.
- Individual incidents were discussed in senior team meetings and lessons learnt were fed back to staff through handovers and through a staff newsletter which was published on a monthly basis.
- From the beginning of November 2015 to the end of January 2016 the urgent care centre reported 49 incidents. The types of incidents reported included patients who had absconded from the department, when there had been a delay in treatment and medication errors.
- The department had not reported any serious incidents or 'never events' during the same period. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- Staff had an understanding of the duty of candour and when this should be applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Morbidity and mortality was discussed at divisional level. However, the clinical lead for the unit had only recently become involved with this process so that lessons were learnt and improvements were made to the service when required.

Cleanliness, infection control and hygiene

- All areas of the department were generally visibly clean and tidy.

- We checked a sample of equipment and mattresses which were found to be visibly clean and free from rips. However, we observed one curtain in the plaster room that had been contaminated and had not been removed. We brought this to the attention of the matron who rectified this immediately.
- The trust used an external company to provide housekeeping services. There was no official daily checklist in place to indicate for when cleaning had been completed. However, there were cleaners in the department at the time of inspection.
- If a cubicle became contaminated outside of normal working hours we were told that the cubicle was closed down and cleaning staff were available on an on-call system.
- Material curtains were used in the department and we were told that the cleaning staff had a system in place to change these on a regular basis. However, there were no labels or documentation to confirm when they had last been cleaned.
- There were no incidences of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (CDIFF) recorded in the department between January 2015 and the time of inspection.
- Infectious diseases such as Ebola were screened at reception and there was a procedure in place to deal with this if there was an occurrence. We were told that patients with an infectious disease were managed in an isolated cubicle and personal protective equipment (PPE) was available for staff when required.
- Staff had regard for and adhered to current infection prevention and control guidelines such as 'bare below the elbow'. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care. Hand gel was available at all entry and exit points as well as in individual cubicles.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We found that sharps and clinical waste were stored appropriately.
- Information relating to cleanliness and infection control audits were posted on the walls within the department so that patients, visitors and staff were kept informed.
- In the 2014 CQC accident and emergency survey, the trust scored 8.5 out of 10 when patients were asked how clean the departments were. However, this could not be disaggregated specifically for Rochdale Urgent Care Centre.

Environment and equipment

- There were several cubicles available for the treatment of adults and children but the design of the department meant that not all of the cubicles and treatment areas were visible from the main staff areas. However, patients had access to call bells and staff told us that this risk was managed by using cubicles that were visible for higher risk patients.
- There was a designated cubicle that could be used for patients who were seriously ill or needed resuscitation. We found that there was appropriate equipment within this area, including two resuscitation trollies (one for adults and one for children). There were also appropriate resuscitation guidelines for staff to use.
- The trust policy stated that the resuscitation equipment must be checked on a daily basis. However, in the two week period leading up to the inspection, this equipment had not been checked on four occasions.
- There was a checklist of equipment and emergency drugs that should be present and we found that trolleys were stocked with appropriate equipment including emergency drugs in line with this at the time of the inspection. However, we found a bag valve mask resuscitator in the paediatric trolley without any packaging which meant that there was no guarantee that it would be sterile or in date if used. We raised this with the senior staff at the time of the inspection and it was rectified immediately.
- The department had a room for the assessment of patients with mental health concerns. The room was commissioned to comply with the Royal College of Psychiatry safety requirements in that it had two doors and a panic button available for staff to use. However, there was a clinical waste bin attached to the wall of the room which could be used to harm either a patient or a member of staff. There was no evidence of a risk assessment being completed for this.
- We checked a sample of electrical equipment and found that on some occasions they had not been checked for

electrical safety. For example, we found that portable appliance test (PAT) dates had expired on a portable blood pressure machine and a lamp that was being used in the ophthalmology room.

- We also saw that the PAT test and service date had expired for the looker machine (a machine that cuts plaster casts when they are being removed) in the plaster room. However, we found that generally staff had regard to checking dates of last service or expiry prior to use and medical equipment was stored appropriately.
- There was an on-site security team 24 hours per day. They were not based within the department during core hours but there was CCTV coverage in the main areas and in the hospital grounds. Staff told us that security responded quickly when needed.
- The management team completed monthly audits to ensure that the environment and equipment complied with appropriate standards. Records showed that between January and December 2015, the average compliance rate for this was 96.52%. Patient-led assessments of the care environment (PLACE) had been carried out during the same period and the average monthly result of this was 90.56%.
- In the 2014 trust-wide CQC accident and emergency survey, the trust scored 9.4 out of 10 for how safe patients felt when asked if they felt threatened by other patients or visitors while in the department. This was similar to other trusts but this could not be disaggregated specifically for Rochdale Urgent Care Centre.

Medicines

- Medicines, including controlled drugs, were stored securely in line with legislation and trust policy.
- Records indicated that staff carried out daily checks on controlled drugs and a group of recorded drugs to ensure compliance with trust policy. However, in the three weeks prior to the inspection, there were two occasions when the book had not been signed to confirm that checks had been completed.
- Medicines requiring cool storage at temperatures between two and eight degrees centigrade were appropriately stored in fridges. Records indicated that daily temperature checklists were regularly completed. However, we were told that there had been an issue with new thermometers on the fridges and these were unable to monitor temperatures accurately. Staff told us that they were currently using portable thermometers to ensure that medication was stored at the correct temperature while waiting for this to be fixed. We found that drugs stored in the fridge had been checked regularly and were in date.
- The pharmacy department was responsible for maintaining stock levels on a daily basis. We checked a sample of general medicines and found them to be in date.
- A small number of staff had been trained in administering patient group directive (PGD) medication and we saw that the department kept an up to date register for this. Patient group directives allow the administration of specific medications without the need for a prescription or an instruction from a prescriber.
- At the time of inspection there were no patients who were being treated with medication. However, we saw that there was a section on individual patient records that could be used to record this if needed. Allergies were clearly noted on the front page of the notes.
- Medications that were prescribed for patients to take home after discharge were recorded on a hospital paper prescription and there was an on-site pharmacy that was accessible during normal working hours. Outside of these times, staff prescribed from a stock of medication that was kept in the department.

Records

- The department used a combination of both paper and electronic records.
- As part of the inspection we checked 10 patient records. We found that they were clear, legible, up to date and signed by a member of staff. Allergies and appropriate observations had been completed. However, we found that early warning scores (EWS)/Manchester Children's Early Warning Score (MANCHEWS) were not completed on seven occasions.
- We saw that all paper records were stored securely in a designated staff area. The electronic system recorded patient history and previous attendances so that staff could look back at information to assist with diagnosis.
- When patients had been discharged their individual record was scanned into the IT system by the administration team.

- The department used an electronic system for triaging patients. This triage sheet was printed and any further information such as medical notes or medications prescribed were hand written.

Safeguarding

- There was an up to date trust-wide safeguarding policy in place which was located on the intranet and staff knew how to find it. Staff were able to give examples of safeguarding concerns and what actions they would take if a concern was identified.
- There was a safeguarding team based in the hospital who were available between the hours of 9am and 5pm, Monday to Friday. Procedures for staff to follow outside of normal working hours were in place, along with a process for contacting external agencies where required.
- The electronic system identified patients who had previously attended any of the hospitals within the trust. External agencies, such as social services, were also able to add information to the system to alert staff of any concerns.
- There was a referral form available to share safeguarding concerns with external agencies.
- We were told that the department undertook a continuous peer review of children's notes that was to review if all appropriate safeguarding concerns had been share. However, compliance levels with this were not recorded and it's not clear how information was gathered or reviewed to identify areas for improvement.
- The management team undertook proactive reviews for initiatives such as child sexual exploitation and had identified groups of potentially vulnerable patients. Notes for these groups were being reviewed on a regular basis so that all cases were identified. Staff had also had training to cover this particular risk.
- All nursing staff in the department had completed safeguarding level 2 for both adults and children. Compliance with safeguarding level 3 training was also high for adults (100%) and children (92%), which were above the trust's target of 85%. However, records indicated that all three substantive medical staff employed in the department were not up to date with safeguarding training but locum doctors told us that this had been provided by their agencies and that their training was up to date.

Mandatory training

- Staff received mandatory and statutory training on a rolling annual basis in areas such as infection control, manual handling and fire.
- Overall compliance for staff in the department was 94% which exceeded the trust target of 85%. However, we found that compliance with some modules of the training was mixed.
- All members of nursing staff (including support staff) were required to complete basic life support (BLS) training. Compliance with training for adults (94%) and children (100%) was high. However, all nurses were required to complete immediate life support training (ILS) but only 50% of staff had completed this for adults and 75% for children. In addition, only 56% of staff (that were required to) had completed advanced life support (ALS) for adults and 25% of staff had completed advanced paediatric life support (APLS) for children. This meant that the department were not always able to ensure that there was an appropriately trained member of nursing staff on every shift.
- The department employed two consultants and a middle grade doctor, one of whom was an instructor in advanced life support.
- We were told that agency staff and locum doctors were expected to complete their mandatory training with their agencies. It was not clear how this was monitored in the department.
- The department did not have a practice education facilitator. However, a member of the clerical staff was responsible for monitoring and updating a spreadsheet that highlighted if individual staff members were up to date with mandatory training.

Assessing and responding to patient risk

- Guidance issued by the Royal College of Emergency Medicine in 2011 recommends that rapid initial assessment (triage) of patients should take place within 15 minutes of arrival. The department continuously failed to meet the national target for 95% of patients to be assessed within 15 minutes. Performance between February 2015 and January 2016 ranged from a monthly average of 58.1% to 78.91%, which was worse than the national average.
- At the time of the inspection the department's information system showed that on several occasions, patients waited between 21 and 47 minutes for an initial

assessment. Senior staff told us that a new triage audit had been introduced which was designed to identify common problems associated with this process so that improvements could be made.

- The service had failed to meet the Department of Health one hour target which measured the median average time of arrival to the start of definitive treatment between September 2015 and the time of inspection. Average monthly waiting times for this varied between 65 and 90 minutes. At the time of the inspection we saw a number of patients waiting for over an hour to be seen by a member of nursing or medical staff.
- Staff used different tools to triage patients and assess their clinical condition. These included an early warning score (EWS) for adults and the Manchester Children's Early Warning Score (MANCHEWS) for children and young people. The Manchester Triage System (MTS) was also used to determine the priority of patients based on their injury or condition.
- The EWS and MANCHEWS systems used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care or more frequent observations than others. A EWS or MANCHEWS was required as part of the patient's initial assessment at triage.
- The management team had identified that staff were not recording the EWS or MANCHEWS consistently as part of the triage and reassessment process. The results of a documentation audit that had been completed between October 2015 and January 2016 showed that EWS had been completed on 0% of occasions and MANCHEWS in 7% of cases. In addition to this, out of ten records that we reviewed, seven of these had not been completed. There was an action plan to improve this and we were told that work was being done with staff to improve compliance. However, the audit also showed some positive results which included 90% of records being accurately dated and all necessary patient information was recorded on 100% of occasions.
- Patients who presented with certain conditions or injuries sometimes required further treatment at a local accident and emergency department. If this was the case, then arrangements were made by staff for the patient to be safely transported by ambulance. If a patient's condition deteriorated they were managed in the resuscitation area until the ambulance crew arrived.
- We were told by reception staff that although there was no formal training process in place, they relied on experience in recognising patients who needed assistance and were able to give us examples of circumstances when they would notify nursing staff immediately. Receptionists were able to add a symbol to the electronic system to alert triage staff if a patient required more urgent attention.
- An escalation process was in place for staff to implement if the department started to exceed capacity.

Nursing staffing

- The required nursing establishment had been calculated in June 2015. Safer staffing guidelines produced by the National Institute for Health and Care Excellence (NICE) were considered when doing this.
- The department had a mixture of band 3 healthcare assistants, band 5 nurses, emergency nurse practitioners and advanced nurse practitioners. Against the calculated establishment there was one band 5 and one band 6 nursing vacancy at the time of the inspection.
- The department always tried to achieve an appropriate skill mix of band 5 nurses, band 6 nurses and nurse practitioners on every shift. However, this was not always possible. Staffing levels and skill mix were identified and had been on the divisional and departmental risk register since October 2013.
- We saw that the department was fully staffed at the time of the visit. However, we looked at rotas for a three week period to the time of inspection and saw that there were eight occasions when the numbers of nurses fell below the establishment. In addition, on three of those occasions there had been difficulties in achieving the appropriate skill mix because there were no emergency nurse practitioners on shift. These were all night shifts and meant that there were only band 5 nurses to provide care and treatment in support of a middle grade doctor.
- A peer review for all accident and emergency departments and the urgent care centre had been completed by a neighbouring trust in January 2016. This provided a review of the current nursing establishment to help determine if it was appropriate. The report recommended that the number of emergency and advanced nurse practitioners should be increased but said that there was no need for the number of band 5 nurses to be altered.

Urgent and emergency services

- The department relied on the daily use of agency staff, particularly in ensuring that there were an appropriate number of emergency nurse practitioners available for every shift. When this could not be achieved locum doctors were used instead.
- The department were unable to provide a paediatric nurse on every shift as there were only two paediatric nurses at the time of the inspection, including one band 5 and one band 7.
- Advanced nurse practitioners worked between 8am and 10pm at the time of the inspection but we were told that plans were in place to extend their availability to 2am.
- Information provided by the trust showed that between May and December 2015 sickness rates were 2.67% for nursing staff in the department. This was below the trust target of 5.87%. However, during the same period staff turnover was 14.49% which was much higher than the trust target of 8%.

Medical staffing

- There were two consultant positions in the department, both of which were filled. One was the clinical lead for the department and both were available between 9am to 5pm Monday to Friday. Out of hours there was a consultant on-call who was based at Oldham hospital.
- The department had identified the need for six middle grade doctors. However, there was only one employed substantively at the time of the inspection. This meant that the department was heavily reliant on the use of locum doctors.
- We observed rotas from the beginning of February 2016 to the time of inspection. In this period the department ensured that there was middle grade cover 24 hours a day on all but one occasion. We were told that in this instance a middle grade doctor from the clinical assessment unit, which was adjacent to the department, was used for cover.
- We were told that when locum doctors were used, the department tried to use the same staff so that they were familiar with the environment and protocols.
- Locum staff were given a local induction so that they could familiarise themselves with policies and procedures.
- Doctors handed over to each other at the beginning and at the end of every shift to maintain continuity of care.

Major incident awareness and training

- There was a major incident lead who was responsible for the maintenance and update of documentation and equipment held within the department. The lead also assisted in providing staff training for CBRNE (chemical, biological, nuclear and explosives) which was included as part of the mandatory training programme.
- There was a major incident and business contingency plan in place for the department. This was last updated in 2013. It was due for review and update in July 2015 but at the time of inspection this had not been completed.
- The department had a file that was updated by the major incident lead. We saw that this had recently been reviewed and action cards were available highlighting key responsibilities for staff members in the event of a major incident. There was a register to complete when staff had read the updates. However, this had only been completed by a small number of people.
- There was a major incident store cupboard in the department. Records indicated that the equipment was checked on a regular basis and it was in date.
- There was also a designated treatment room for major incidents with flowcharts for conditions such as viral haemorrhagic fever available.
- We were told that in the event of a major incident, the urgent care centre had a defined role in dealing with walking casualties. The department also worked in conjunction with the ambulance service when needed.
- The department had a winter resilience plan which was available on the trust intranet.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

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

- Audits did not provide a representative view of the efficacy of care and treatment. This was because many of the audits undertaken, such as sepsis, were not appropriate for non-emergency units and some of the

audits included only a very small sample of patients. The lack of appropriate audits being completed limited the opportunities for any lessons to be learned and improvements to be made.
- There was a limited number of care bundles available that could be printed and added to patient documentation for standardisation of care.
- Although there were regular clinical training days planned, they were not always being facilitated due to operational demand.

However,

- Care and treatment was delivered in line with evidence based practice and guidance.
- A mixture of guidelines and protocols were available on the trust intranet for nursing and medical staff to use.
- There was evidence of multi-disciplinary working both internally and externally. There were good systems and referral processes in place to ensure appropriate onward referral where necessary.
- Staff we spoke to had an awareness of mental capacity and best interest decisions and there was access to appropriate support if required.
- Appraisals for staff had been completed in a timely manner and the department encouraged staff to develop within their roles and to acquire extra clinical skills were possible.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence-based practice and national guidance such as those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM).
- There were pathways available for a small number of conditions such as sepsis or fractured neck of femur that could be added to patient notes when required. However, there was a limited number of care bundles available that could be printed and added to patient documentation for standardisation. Nursing and medical staff used free text on most occasions when completing documentation.
- There were additional pathways that had been developed by the department but these were not readily available at the time of inspection and we were told that they were in the process of being added to the IT system. These pathways were for conditions such as head injury and cardiac chest pain.
- We saw guidelines for the treatment of minor injuries and ailments specific to the urgent care centre, however the guidelines were published in 2012 and due for review in 2013. We were told by the clinical lead that they were under review at the time of the inspection.
- Both nursing and medical staff within the department were aware of how to obtain guidance for the treatment of specific illnesses or injuries if pathways were not available. This included access to the trust's intranet which covered issues such as respiratory conditions, toxicology, major trauma and burns as well as head injuries and musculoskeletal injuries.
- Staff had an awareness of how evidence-based practice impacted on their daily responsibilities but were unable to tell us about audits that had been completed or where improvements needed to be made.

Pain relief

- We reviewed 10 patient records during the inspection and saw patients had been assessed for levels of pain and scores had been documented clearly on all occasions.
- We did not see any patients at the time of inspection who had been prescribed pain relief while in the department.
- Records indicated that pain relief was prescribed by either nurse prescribers or medical staff prior to discharge when needed.
- The 2014 CQC accident and emergency survey showed that the trust only scored 6 out of 10 when patients and relatives were asked if pain relief was received in a timely manner. This was similar in comparison to other trusts nationally but the data was for the trust overall and could not be specifically disaggregated for Rochdale Urgent Care Centre.

Nutrition and hydration

- There were vending machines available in the waiting area of the department providing food and drink. There was also a restaurant available within the hospital building.
- We were told that food and drink could be made available while patients were waiting in the cubicles if required.
- Results from the 2014 CQC accident and emergency survey showed that the trust scored 5.9 out of 10 for

providing suitable food and drink, which was similar to the performance of other trusts. However, the data was for the trust overall and could not be specifically disaggregated for Rochdale Urgent Care Centre.

Patient outcomes

- The trust participated in audits recommended by the Royal College of Emergency Medicine (CEM) but these audits may not be an accurate of measurement of the type of service that the department provided. For example, the audit department had completed a neutropenic sepsis audit between June and December 2015. Despite there being 135 patients included in the study covering four departments, only two patients in the sample had presented at the urgent care centre.
- We were told that there was a central audit department in the trust that organises and carries out clinical audits. However, staff could not tell us what had been completed as part of this programme apart from a sepsis audit, a neutropenic sepsis audit and a local audit in relation to clinical record keeping.
- The clinical lead had worked alongside the trust's audit department and created a 12 month audit plan to measure the effectiveness of the services that the department does provide such as wound care and head injuries.
- We saw that some local audits including a documentation audit and a triage audit had recently been undertaken and we were told that an alcohol audit and a high impact intervention audit had been undertaken but we were not shown evidence of this. This information was used to monitor the quality of service provided and to help identify areas that required improvement. We saw that as part of the documentation audit there were plans to feedback results to individual staff through the appraisal process.
- Unplanned re-attendances to the department within 7 days were monitored on a monthly basis. Between January 2015 and December 2015, the rates of re-attendance during this period varied between 4% and 6%. For three months, the rate of re-attendance exceeded the national target of 5%.
- The department also monitored patients who left without being seen on a monthly basis. Between January 2015 and December 2015 this was consistently better than the national target of 5%. Performance ranged from between 2.5% and 5% in this period.

Competent staff

- We looked at appraisal records for nursing staff. The compliance rate with this was 85% at the time of the inspection, which was in line with the trust target.
- Appraisals for substantive medical staff were completed by a consultant and these were all up to date at the time of the inspection. We were told that locum staff were also appraised if they worked in the department on a regular basis.
- Staff had been allocated a named mentor to complete their appraisal with. Staff told us that they could request training and development within the appraisal process and we saw evidence that staff were being supported to develop their skills. For example, there was a nurse in the department training to be an emergency nurse practitioner and there were two emergency nurse practitioners training to be advanced nurse practitioners.
- There was a preceptorship plan in place for new nursing staff. New members of staff were given an induction booklet to complete and were assigned a named mentor. Clinical induction lasted for four weeks, where new staff could work as supernumerary (supernumerary means they were not included in the daily staffing numbers so that they could learn without specifically being assigned patients to care for as an inducted member of staff would).
- We were told that a number of band 3 support workers had been trained in venepuncture and were able to take blood from patients. Staff had to achieve an advanced apprenticeship in health before they were allowed to do this.
- We saw that a staff education board had recently been developed which had a 'monthly theme'. This included topics such as stroke care. Staff were given an opportunity to have input in deciding what themes to present.
- The department had developed a training room that was used for training sessions that were facilitated for staff.
- The department had access to regular training days. However, we were told that this had not been facilitated on a regular basis due to staffing demand. This had been identified as a current risk on the departmental risk register.

- There were two members of staff trained to be confirmers of registration. This meant that they were able to confirm whether members of staff had re-validated with their professional bodies when required.

Multidisciplinary working

- The department worked with teams within and outside the hospital on a regular basis.
- There was access to the rapid assessment, interface and discharge (RAID) team who assessed patients with mental health concerns. This service was available 24 hours a day and we were told although they were based at a different site they saw patients at the urgent care centre so that they did not have to be transferred to a different department. Staff told us that when needed they responded in a timely manner.
- The department sought advice from departments within the hospital if required such as the oasis unit which provided services to patients living with a cognitive impairment, such as dementia.
- The department worked alongside the transfer of care team who provided links to community services such as the crisis team, social services, the re-ablement team and children's teams.
- There was an alcohol liaison officer employed by the department who also worked alongside external voluntary organisations and charities such as those that dealt with housing issues and a charity who provided services for the elderly and another who provided a young people's drug and alcohol service.
- Internal referrals for patients could be made to Oldham hospital which provided surgical, orthopaedic and paediatric services, Fairfield hospital which provided a specialist stroke service or North Manchester General Hospital which provided maxillo-facial and urology services.

Seven-day services

- The department saw adults and children. It was open 24 hours a day, 7 days a week.
- There was consultant cover on the department between 9am and 5pm Monday to Friday. Outside of these hours there was a consultant on call available who also covered the accident and emergency department at Oldham. There was middle grade doctor cover 24 hours a day, 7 days a week.
- A radiology department was available in the hospital, which was accessible between 8.30am and midnight, 7 days a week.
- The department provided an ophthalmology service during normal working hours and there was a 24 hour on call service available.

Access to information

- Staff throughout the department including receptionists, nursing and medical staff were able to use the IT systems in the department.
- Staff had access to national guidance reference material via the trust intranet that supported clinical decision making. There was also access to trust policies and procedures.
- Diagnostic results such as x-rays and blood tests were added to the electronic system so that they were reviewed by an appropriate member of staff.
- Patient records were scanned into the IT system on discharge and were available to staff if a patient re-attended.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date policy that covered consent, mental capacity and deprivation of liberty safeguards (DoLS), which was accessible to staff on the intranet and staff knew how to find it.
- We were told that the department rarely saw patients who lacked capacity to make their own decisions about care and treatment but staff had regard to best interest decisions and knew how these could be made. If further support was needed there was access to staff from the oasis unit within the hospital that catered patients living with a cognitive impairment, or the rapid assessment and intervention team (RAID) who were based at a different site. These were both available 24 hours a day.
- There was no specific training for mental capacity and DoLS. However, we were told that this was included as part of level 2 and level 3 safeguarding training.

Urgent and emergency services

Are urgent and emergency services caring?

Good

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

- We saw that patients were treated with dignity and respect. Staff took steps to protect the dignity and privacy of patients when providing assessment and treatment.
- We reviewed a sample of patient records during the inspection and saw that treatment had been discussed with them, including a plan of how their injury or complaint was being managed.
- Staff spent a sufficient amount of time with patients for any concerns to be discussed.
- Patients and relatives spoke positively of their experience within the department.

Compassionate care

- Patients and relatives were positive about their experience and interactions they had with staff.
- Patients were treated in a kind and considerate way. Staff took their time to communicate with patients sensitively and appropriately.
- Patients were treated with dignity and respect. Their privacy was maintained during examinations.
- Reception staff were sensitive if a patient wanted privacy when discussing the reason for attending the department. They made a note for the triage nurse and their reason for attendance could be discussed in a separate room.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Results from the survey between April 2015 and October 2015 showed the trust consistently scored below (worse than) the England average, with only 81% to 83% of patients indicating that they were positive about recommending the trust to friends and family. However, this was trust-wide and could not be disaggregated specifically for Rochdale Urgent Care Centre.
- In the 2014 CQC accident and emergency survey, patients gave the trust a score that was similar to other trusts nationally when asked if staff took time to listen to what you had to say and when asked if staff talked about you as if you were not there. However, this was trust-wide and could not be disaggregated specifically for Rochdale Urgent Care Centre.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that staff had discussed their injury or illness in a way that they understood.
- When reviewing patient records we saw that care and treatment plans had been documented and that advice had been given about when to seek further treatment.
- In the 2014 CQC accident and emergency survey, patients gave the trust a score that was similar to other trusts nationally when asked if they had been given information in a way in which they could understand and did a family or friend have chance to talk to a doctor if they wanted to. However, this was trust-wide and could not be disaggregated specifically for Rochdale Urgent Care Centre.

Emotional support

- We observed staff providing reassurance and comfort to patients. Staff took time to understand the patients' needs to enable them to best address their concerns.
- In the 2014 CQC Accident and Emergency survey, patients gave the trust a similar score to other trusts nationally when asked if a member of staff took time to provide reassurance if nurses or doctors had discussed any fears or anxieties about their condition or treatment. However, this was trust-wide and could not be disaggregated specifically for Rochdale Urgent Care Centre.
- Chaplaincy services were available for patients and relatives if required Monday to Friday, 9am to 5pm. There was a multi-faith prayer room at the hospital. The trust had guidance for staff on religious faith requirements which enabled staff to access to information to support patients.

Urgent and emergency services

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

Good

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

- The department had performed consistently well in achieving the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours.
- The management team had taken the needs of the local population into consideration when developing the services that were provided.
- There was a separate waiting area for children which had a number of toys. There were also two distraction rooms that were used which were colourful and had books and televisions. The department had employed two paediatric trained nurses who were able to support staff in delivering care and treatment to children.

However,

- There was a trust-wide dementia strategy. However, this had not yet been implemented fully in the department.
- We saw that the department did not receive a large number of complaints. However, on several occasions the department took an extended period of time to respond to complaints and concerns. On most occasions the time for these to be closed ranged from between 103 and 230 days.

Service planning and delivery to meet the needs of local people

- The department had taken into consideration the needs of patients who attend the department and had adapted the environment to reflect this as there was a separate adult and children's waiting area which was available before and after triage. The children's section included a range of toys to keep them occupied while waiting to be seen by a clinician.
- The service had employed two nurses who were paediatric trained and had the experience of providing care and treatment to children.
- There were two distraction rooms available for use. These had been designed for children to use while they were being treated. These rooms included books, toys and a television. They were bright and colourful with murals on the walls. There was also a room available and appropriate for adolescents to use.
- The waiting areas were of sufficient size to deal with the numbers of patients that attended and had been designed so that members of the public were visible to the reception staff at all times.
- A specific entrance was available to enter the department for patients being brought by ambulance due to an increased number of patients meeting the criteria to attend the urgent care centre.
- There was an out of hours GP service based in the department. Patients who met specific triage criteria could use this service.

Meeting people's individual needs

- There were limited systems in place to support patients living with dementia or learning difficulties. The department did not have any link nurses but they could get support from other wards such as the oasis (dementia) unit for advice if needed. The trust had 'this is me' books and signage to identify patients living with dementia but the department had not yet adopted these.
- There was a rapid assessment, interface and discharge team (RAID) being used at the hospital 24 hours a day. They were not based on site but were available to perform psychiatric assessments for patients with mental health concerns in the department rather than the patient being transferred to a neighbouring accident and emergency.
- The department had links with a child and adolescent mental health (CAMHS) team, however patients had to be transferred when an assessment was needed they only saw patients at a neighbouring accident and emergency department.
- There was an alcohol liaison officer in the department who was available during normal working hours. The liaison officer was also available to help with referrals to other services such as housing agencies if needed.
- Staff had access to language line which was a telephone translation service. We were told that this was used on a regular basis due to the cultural demographics of patients living in the local area.

- We were told that a translator provided by an external service could attend the department but staff told us that they were not able to access this easily as this service had become less accessible.
- Advice leaflets were available for different conditions. They were available either in the department or on the internet and were available in a variety of languages that reflected the most common ethnicities in the area.

Access and flow

- Between January 2015 and December 2015, the department continuously met the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours.
- The percentage of patients waiting between 4 to 12 hours for admission to the hospital from the time the initial decision to admit was taken was consistently better than the England average from January 2015 to December 2015.
- The department accepted patients who either self-presented or arrived by ambulance. However, on some occasions patients needed further treatment in a neighbouring accident and emergency department. Staff made appropriate arrangements for patient transfer if needed.
- Following triage some patients were referred to the GP services that were available on site if their condition allowed. Staff told us that this service took pressure off the department.
- Staff told us that waiting times were sometimes impacted by the difficulties in achieving the right skill mix of staff. For example, if there was a shortage of emergency nurse practitioners this added pressure to the medical staff as they then had more patients to review.
- There was a clinical assessment unit in the hospital which was used for patients who were either being admitted to the hospital or required a care package being put in place before being discharged.

Learning from complaints and concerns

- There was a trust-wide policy available for handling complaints on the intranet, which included time limits of how quickly complaints should be responded to.
- There was a patient advice and liaison (PALS) service available if patients wanted support when making a complaint.
- Reception staff knew how to provide information to patients or relatives about how to make formal complaints. We also observed information about making complaints in the main waiting area and leaflets were available for patients and relatives.
- Between January and December 2015 the department had received a small number of complaints and we took the time to review all ten of these. There were six occasions during this period complaints were not dealt with in a timely manner. For example, the number of days taken to close these complaints ranged from 130 days to 203 days. We also saw that a number of complaints were still outstanding from between March and October 2015.
- Managers in the department said that they recognised that this was a problem. However, the senior management team told us that there were no current plans to change the process of how complaints were managed centrally.
- Despite the delays in closing complaints we saw that complaints were discussed at senior management meetings and information about complaints was cascaded to staff through monthly newsletters.

Are urgent and emergency services well-led?

Good

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

- We saw that the leadership had a set structure and all positions were filled. The department and the division of integrated care and community services had a vision and strategy which staff were able to identify with.
- Internal and external meetings were held on a regular basis. External meetings included regular engagement with commissioners.
- Staff told us that there was a positive culture within the service and that management were both visible and approachable. Staff felt supported with the jobs they were doing and that development within the department was encouraged.

- The department had identified key points in order to improve the service and were in the process of implementing processes such as regular clinical audits so that clinical effectiveness could be measured and improved.
- The department had a risk register which identified current risks appropriately. These fed into the divisional risk register.

However,

- There were some risk assessments that were out of date and required review.
- There was little evidence to show how the department measured the quality of the service.

Vision and strategy for this service

- The trust had a clear vision and strategy that was based on values, was quality driven, responsible and compassionate. We saw that these values where displayed around the department for patients, relatives and staff to see.
- The urgent care centre was run as part of the division of community and integrated care services within the Pennine Acute NHS Trust. This was different to the three neighbouring accident and emergency departments within the trust as they were run under the division of medicine.
- The department had strong links with commissioners and the division had a five year forward plan in developing and sustaining service improvement.
- The management team had a vision for the department to be general practitioner (GP), doctor and nurse-led. The department had identified the need for, and had agreed the funding to advertise five middle grade and five speciality GP positions. At the time of the inspection, management were finalising job descriptions for these positions before being advertised.
- Staff we spoke to were able to identify with what the service was trying to achieve.

Governance, risk management and quality measurement

- There was a divisional and departmental risk register which was up to date and measured levels of risk for current issues such as staffing and staff not being able to attend training days due to operational demand. There was a correlation between what managers described as their key risks and what was recorded on the risk register.
- We saw that the department had a risk assessment file which included risk assessments for issues such as risk of exposure to violence and aggression and manual handling. However, we saw that some of these risk assessments were out of date and required review.
- There was little evidence to show how the department measured the quality of the service. Whilst the clinical lead had begun to implement processes such as local audits, further improvement was required.
- We saw a clinical governance newsletter which was distributed to all staff. This discussed topics such as staff sickness and staffing, mandatory training, reported incidents and complaints.
- There was a weekly senior team meeting in which topics such as incidents and complaints were discussed.
- The divisional management team held locality planning board meetings which included external stakeholders such as clinical commissioning groups and a local charity. The management team felt that these were important in developing the services that were provided by the department further.

Leadership of the service

- There was a clear leadership structure within the service. Staff told us that they felt that the management team were both approachable and supportive.
- At divisional level there was a lead nurse and a service manager. Both had been involved with the hospital for a number of years and were fully aware of what current risks and challenges the department faced.
- At departmental level there was a matron who had only been in post for a few weeks prior to the inspection. The matron was an emergency nurse practitioner by background and again had been part of the department for a considerable length of time.
- There was a consultant lead within the department who had worked at the hospital many years ago and had recently returned to take up the post. The lead was responsible for medical staff review, leading training days and had recently developed a 12 month audit plan to measure the effectiveness of the service and develop clinical pathways which could be used by nursing and medical staff in the department.

- We saw that leaders were visible within the department at the time of inspection and we were told by staff that this was the case on a daily basis.

Culture within the service

- We found there to be a positive culture within the department and we saw examples of staff working and communicating well together.
- Staff did raise concerns about the lack of training time which they felt was important to be able to maintain and improve their clinical knowledge and skills.
- Information gathered in the NHS staff survey 2015 for the trust showed that only 49% of staff would recommend the trust as a place to work. This was worse than similar trusts. However, this was trust-wide data and could not be specifically disaggregated for Rochdale Urgent Care Centre.

Public and staff engagement

- A member of staff from the department had completed a public survey to gather people's views which was used to help develop the service. However, this had last been completed in September 2015. Examples of questions asked included did you feel that you had enough time to ask questions, were you given enough privacy when being treated and where you involved as much as you wanted to be about your decisions, care and treatment. The overall response to this was positive.
- The department had recently held an event for homeless people which we were told was a big success. This gave the department an opportunity to provide support to the local population and was well attended. It also allowed staff to gain insight to their needs and promote the services that the unit provided.
- The service had introduced a 'sad, mad and glad board' for staff to raise what they were happy and unhappy with. We were told that information for this was fed into weekly team meetings. However, we saw that there had not been many staff who had used this at the time of the inspection.
- The department provided a dedicated education room for staff to use for training and development. We saw a number of noticeboards highlighting a number of learning 'themes' and also feedback and learning from incidents and complaints.
- Information had been extracted from the trust's website displaying the department's compliance with Department of Health targets including triage and time to definitive care. We observed the information to be up to date, however was not always displayed in a way that was easy to understand.

Medical care (including older people's care)

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

Information about the service

Medical services at Rochdale Infirmary are provided from two wards and an endoscopy department. The clinical assessment unit (CAU) accepts patients via GP referral, or patients may be admitted via transfer from other trust sites or the urgent care centre. There are 16 beds and two single sex areas with space to accommodate up to six patients for GP consultations. Patients are assessed based on clinical need and are not expected to require access to specialist services based at the other sites within the trust. They are expected to require an admission of less than 72 hours. The oasis unit is a specialist dementia ward. There are five beds in this unit, offering medical treatment to patients with a diagnosis of dementia or delirium. The unit accepted patients from CAU, and accident and emergency units or medical admissions units at other trust sites. Both CAU and the oasis unit were commissioned for patients from the Heywood, Middleton and Rochdale CCG area only. The endoscopy unit offers endoscopy services to outpatients. There are two endoscopy suites with a two stage recovery area, the first stage containing nine recovery pods and a chaired area for second stage recovery. Within this department there is also a manometry room.

We visited the hospital as part of our announced inspection on 24 February 2016. As part of our inspection, we observed care and treatment and looked at five sets of patient records and three prescription charts. We spoke with nine staff, including nurses, doctors, consultants, support workers, managers and allied health professionals. We also spoke with three patients using the services at the time of our inspection. We looked at information provided by the trust and other relevant information we requested.

Medical care (including older people's care)

Summary of findings

Medical services (including older people's care) at Rochdale Infirmary were good across all five domains.

We rated safe as good because;

- Incidents were reported and learning was shared via a monthly newsletter. Harm free care was monitored and measured monthly and the wards we visited had a good track record on safety.
- Medical services were clean and tidy. Infection prevention audits were completed and showed that the areas we visited were compliant with trust policies. We saw staff using personal protective equipment such as aprons and gloves and observed them washing their hands appropriately. Medicines were stored correctly and securely.
- Overall mandatory training was 89% which was just below the trust target of 90%. Staff were aware of their responsibilities in relation to safeguarding. Safeguarding children and adults level two had been completed by 93% of staff.
- There were systems in place to ensure that patients were assessed and risks were monitored and minimised. A clear triage system was in place to ensure that patients were admitted to CAU appropriately and that those requiring specialist care were directed to other hospital sites within the trust. Early warning scores were used correctly and there was a clear process to transfer patients if they became more acutely unwell. Endoscopy carried out low risk procedures.
- Nursing staffing had been calculated using a recognised acuity tool and shift fill rates were very high. Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital. There were systems in place to induct agency nurses and doctors.
- There was a trust wide business continuity plan in place to ensure services could continue to run in the event of staff shortages, equipment failure or a major incident.

However,

- Infection control training rates fell below the trust target, particularly for staff with patient contact roles. The manometry room was not fit for purpose and requires improvements to be made.
- Records were not always complete with patient details and we saw that they were not always secured within a medical records folder. The approach to documentation in records was not consistent between staff.
- Nursing staffing numbers on the oasis unit did not take account of when mental health nurses were not available. The endoscopy unit was unable to work at full capacity due to nursing staff shortages.

We rated effective as good because;

- Care and treatment was delivered in line with national guidance and best practice. Locally produced guidelines reflected evidence based care and treatment. Patients were reviewed daily by consultants.
- Local audits were completed and the endoscopy unit was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- Pain was assessed and patients received timely pain relief. Patients had their nutritional needs assessed.
- The average length of stay was lower (better) than the England average and the overall risk of readmission was also lower.
- Staff were supported to develop their skills, but appraisal rates were low in some areas. Staff worked closely with other members of the multi-disciplinary team and with other agencies. Staff had access to the information they needed to provide effective care and treatment. They understood the Mental Capacity Act and deprivation of liberty safeguards and took consent appropriately.

However;

- However, performance on the national heart failure audit was poor in comparison the England average and care for this group of patients required improvement.
- There was access to diagnostic testing, but if this was required out of hours or at weekends patients were transported to other sites within the trust.

We rated caring as good because;

Medical care (including older people's care)

- Staff were kind, caring and compassionate. They maintained the privacy and dignity of patients in their care.
- Patients were cared for in an individualised way of the oasis unit and their carers and families were encouraged to be involved in their care. Patients were given enough information about care and treatment and had time to ask questions.
- Friends and family test results showed that 97.5% of patients would recommend medical services at Rochdale Infirmary. Open visiting was in place and there was access to specialist mental health services.

We rated responsive as good because;

- Services at Rochdale Infirmary had been planned to meet the needs of local people, although they did not provide a full range of specialist services. Ambulatory care was available seven days a week, reducing the need for patients to be admitted to hospital.
- Referral to treatment times for the trust for admitted (adjusted) patients were above (better than) the England indicator and England average.
- The specialist oasis unit was thought to be the first of its kind in a hospital in England. This type of unit is an example of outstanding practice.
- There were clear admission and discharge processes in place and a transfer of care team was available to support with more complex discharges.
- The oasis unit was designed to be dementia friendly. The unit reflected the needs of patients living with dementia and staff delivered patient-centred care. There was a trust wide dementia strategy and a nurse consultant in dementia care. Patients with a learning disability were identified and there was a learning disability specialist nurse.
- Patients were given information about how to make a complaint. There had been four complaints about medical services at the hospital between 1 December 2014 and 31 December 2015. Complaints were discussed at clinical governance meetings and a quarterly learning from experience was sent to the trust board.

However;

- Bed occupancy rates were high at around 93% and there was sometimes a waiting list to access the oasis unit.
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We rated well led as good because;

- Staff were aware of the trust vision and values. There was a service improvement plan in place for the division of integrated community services.
- There was an established governance structure in place that fed back into the overall governance system for the trust. The risk register was up to date and detailed actions taken to reduce identified risks.
- Leaders were visible and staff felt supported by them. They felt there had been a positive change in the overall leadership of the trust in the past 18 months.
- Staff described the culture as friendly and supportive and they were proud of the services they provided. Staff meetings were held regularly and success was celebrated through weekly communications from the chief executive and annual staff awards.
- Staff had been involved in the development of the trust vision and values and the "healthy, happy, here" programme of work.
- Leaders were supported to be innovative in the way they worked and were able to give examples of changes they made to improve services for patients such as an onsite blood laboratory and an onsite doppler service. The oasis unit was being expanded by a further five beds following a successful pilot of this specialist dementia ward.

However;

- Although there were open and honest care boards detailing actions taken from patient feedback, there had been no local patient surveys carried out recently.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because;

- Incidents were reported and learning was shared via a monthly newsletter. Harm free care was monitored and measured monthly and the wards we visited had a good track record on safety.
- Medical services were clean and tidy. Infection prevention audits were completed and showed that the areas we visited were compliant with trust policies. We saw staff using personal protective equipment such as aprons and gloves and observed them washing their hands appropriately. Medicines were stored correctly and securely.
- Overall mandatory training was 89% which was just below the trust target of 90%. Staff were aware of their responsibilities in relation to safeguarding. Safeguarding children and adults level two had been completed by 93% of staff.
- There were systems in place to ensure that patients were assessed and risks were monitored and minimised. A clear triage system was in place to ensure that patients were admitted to CAU appropriately and that those requiring specialist care were directed to other hospital sites within the trust. Early warning scores were used correctly and there was a clear process to transfer patients if they became more acutely unwell. Endoscopy carried out low risk procedures.
- Nursing staffing had been calculated using a recognised acuity tool and shift fill rates were very high. Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital. There were systems in place to induct agency nurses and doctors.
- There was a trust wide business continuity plan in place to ensure services could continue to run in the event of staff shortages, equipment failure or a major incident.

However,

- Infection control training rates fell below the trust target, particularly for staff with patient contact roles. The manometry room was not fit for purpose and requires improvements to be made.
- Records were not always complete with patient details and we saw that they were not always secured within a medical records folder. The approach to documentation in records was not consistent between staff.
- Nursing staffing numbers on the oasis unit did not take account of when mental health nurses were not available The endoscopy unit was unable to work at full capacity due to nursing staff shortages.

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Incidents

- Staff were encouraged to report incidents via an electronic reporting system
- Between December 2014 and November 2015, 160 incidents were reported. The majority of these incidents were graded as no or low harm indicating a good reporting culture.
- Learning from incidents was shared via a monthly governance newsletter. 'Lessons learnt' events were held with action plans taken forward.
- There was a prompt to consider the duty of candour on the incident reporting system. The duty of candour regulation is in place to ensure trusts are open and honest with people who use services and inform and apologise to them when things go wrong with their care and treatment. Senior staff were able to describe a recent example of how the duty of candour was applied following the development of a pressure ulcer whilst in hospital.
- A trust wide duty of candour policy was in place with an accompanying leaflet to improve staff understanding. Senior managers received specific training in the duty of candour, root cause analysis and being open.
- Mortality and morbidity meetings were held monthly.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- Monthly nursing metrics checks were completed and reported. This included monitoring of performance in relation to pressure ulcers, infection prevention, continence, tissue viability and nutrition. Over the six month period from August 2015 to January 2016, CAU scored an average of 95% and oasis unit scored 99%.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- Medical services at Rochdale Infirmary were visibly clean and tidy. We observed staff using personal protective equipment (PPE) and washing their hands appropriately.
- A green 'I am clean' labelling system was in use on commodes and there was a daily register to document the cleaning of commodes.
- Up to date infection prevention training had been completed by 86% of all staff within medical services, although this fell to 83% for staff groups who had direct contact with patients. The trust target was that 90% of staff would be up to date with this training.
- Infection control audits were carried out annually. If audits did not meet the trust standards then a re-audit was completed within three months. The most recent audits showed that CAU was 93% compliant and oasis unit was 94% compliant against the trust target of 85%. Actions had been agreed for the areas which did not meet the standards set by the infection prevention team.
- There had been no cases of hospital acquired clostridium difficile or MRSA bacteraemia within the twelve months prior to our inspection.
- Monthly handwashing, catheter and cannula audits were carried out by infection prevention and control link nurses to ensure compliance with National Institute of Health and Care Excellence (NICE) guidance to reduce the risk of infection. The most recent audits showed 100% compliance on the oasis unit. There were meetings for infection prevention and control link nurses bi-monthly for each site.

Environment and equipment

- On the oasis unit, we saw that linen was stored in the clean utility room, along with medical pulp products. This was due to a lack of storage space within the environment. On CAU, we saw seven bags of dirty linen inappropriately stored on the floor in the sluice. Dirty linen bags should be sealed and removed from the clinical area immediately.
- Patients who had been identified as at risk of developing pressure ulcers were provided with appropriate mattresses and cushions as necessary.
- The manometry room (situated within the endoscopy department) was not fit for purpose. The room was cramped and cluttered with a large amount of clinical and office equipment, including a non-wipeable office chair. Clinical supplies and medical pulp products (vernacare) were stored inappropriately in this room. During lower manometry investigations, patients were required to use a static commode within this room with little privacy or dignity. The commode pan was emptied within the sluice for endoscopy which involved walking through the first and second stage recovery areas for endoscopy. This could pose an issue for infection control. We were told that a business case had been developed which included the need to move to more appropriate facilities. This issue had previously been identified in the JAG accreditation report in August 2014 and the department had been advised that plans to improve this area should be made quickly at this time.

Medicines

- Medicines were stored appropriately. Controlled drugs (CDs) were kept secure in a locked cupboard. We checked the CD book and saw that drugs were correctly signed by two registered nurses and all documentation was correct. CDs were checked three monthly by the pharmacy team. CAU also used 'recorded drugs'. This included medication such as diazepam, zopiclone and dihydrocodeine. These were stored in a locked cupboard and were signed out by one registered nurse.
- Fridge and room temperatures were checked and recorded daily. All medicines we checked were in date.
- Medications were prescribed via an electronic prescribing system, although paper based records were used for intravenous (IV) fluids, warfarin and insulin if the doses were variable.
- There was a trust wide antibiotic policy for adults in place. The most recent audit in July 2015 showed that 100% of antibiotics prescribed at Rochdale Infirmary were compliant with this policy.

Records

- Medical records were paper based, although medication was prescribed electronically. Out of five sets of records reviewed, we saw that one set of records contained six pages without a name or hospital number documented. This set of notes was held together by a treasury tag and also contained loose, unfiled pages. This meant there was a risk that patient information could be misplaced or lost.
- One set of notes did not have the patients allergy status recorded and one set did not have the name of the staff member clearly documented.

- Records were stored in lockable trollies in the ward area on CAU. On the oasis unit, they were stored in a lockable trolley behind the nurse's station.
- On CAU, medical and nursing records were completed separately. There had been a previous trial of combined notes but this had been unsuccessful as staff found that they often needed the notes at the same time.
- On the oasis unit, there were mixed approaches to record keeping. Staff told us that there was a recent change to documentation and that daily nursing evaluations should be completed in the medical notes to ensure a continuous contemporaneous record was kept. However, we checked two sets of notes and found that this system had not been fully implemented. This posed a risk to patient safety as the system was unclear and could lead to omissions or duplication of treatment. This was discussed with the ward manager during our inspection.
- Nursing risk assessments were completed as recommended in national guidelines. These included a falls risk assessment, malnutrition universal screening tool, moving and handling assessment and a bed rails risk assessment. The notes also included a record of signatures appearing in the nursing notes.
- Paper records were scanned onto the electronic system within 72 hours of discharge. Electronic discharge summaries were entered onto the electronic record system at discharge so that there was a record of care and treatment provided for patients re-presenting or attending outpatient areas during this time frame.

Safeguarding

- Staff were aware of their responsibilities in relation to safeguarding children and adults. There was a trust wide safeguarding lead and support could be gained during working hours from the safeguarding team.
- Safeguarding adults and children level two training had been completed by 93% of staff.

Mandatory training

- Overall compliance with mandatory training within medical services was 89% against the trust target of 90%. Mandatory training was a mixture of online and face to face learning.
- Staff told us that their mandatory training had to be up to date in order for them to attend any additional identified training sessions.

Assessing and responding to patient risk

- An early warning score system (EWS) was in place on CAU, oasis and endoscopy. We saw that EWS had been completed and calculated correctly.
- CAU used a telephone triage process for referrals. Triage was carried out by a senior nurse or doctor and clear exclusion criteria were set out. These criteria included patients with cardiac chest pain, possible stroke, women who were pregnant over 32 weeks and patients under 16 years old. We observed this process during our inspection and saw that patients who may require more specialist care were directed elsewhere in the trust.
- A range of risk assessments were carried out by nursing staff including falls assessments and the PURPOSE-T (a risk assessment for pressure ulcers). Patients identified as being at risk had appropriate care plans in place. These risk assessments were completed appropriately in most cases although in one set of notes we reviewed, we saw that a falls risk assessment had identified that a patient was not at risk of falls although a fall was her reason for admission.
- There was a clear process in place for the management of deteriorating patients who required transfer to an alternative hospital for specialist management. We saw evidence from incident reports that this procedure was followed and incidents were raised when issues with the suitability of patients accepted could have avoided the need for an emergency transfer.
- CAU had its own onsite blood laboratory which enabled rapid access to test results for testing such as full blood count, urea and electrolytes, troponin T levels (a test to check for damage to the heart), INR (a measure of blood clotting) levels and D-dimer (to check for a blood clot). This meant that patients could be treated quickly or transferred to specialist facilities in a timely way.
- Endoscopy carried out low risk procedures. Complex procedures were carried out at other sites within the trust where there was access to additional medical support if needed. There were pathways in place to admit patients to hospital if there were complications post-procedure.

Nursing staffing

- The safer care nursing tool had been used to calculate nursing staffing on CAU. This was reviewed six monthly, most recently having been reviewed in November 2015. There was a safe staffing escalation process in place

which included details of actions to be taken by staff at all levels to ensure safe staffing levels. Both wards we visited displayed planned and actual staffing levels for each shift that day.

- Between August 2015 and January 2016, the average fill rate of registered nursing (RN) shifts was 93% during the day and 100% at night on CAU. Shifts on the oasis unit were filled 100% of the time during the same period. Support worker shift fill rates were also very high at over 96.7% for both day and night shifts.
- Between October 2014 and March 2015, 11.5% of shifts were filled by agency staff on CAU. During the same period, 3.5% of shifts on CAU and 1% of shifts on endoscopy were filled by agency staff. There were local induction processes in place for agency staff.
- On the oasis unit, the planned staffing level was one RN and one HCSW per shift. Staff told us that registered mental health nurses from the local mental health trust were often based on the ward during the day, Monday to Friday and that these nurses gave support with care for patients and were used particularly when a more dependent patient required care from two members of staff. The availability of these nurses was not taken into account when planning nursing cover. For example, during our inspection these nurses were on annual leave but nursing cover had not been changed to take account of this. However, there was a process in place to review staffing levels and adjust these if patient dependency levels were high.
- Nursing handovers were held at each shift change over to provide details of patient care, diagnosis, plans and risks.
- Endoscopy completed a daily huddle at 8am to discuss the plan for the day and communicated any relevant information. This had also improved staff satisfaction.
- On CAU, the RN vacancy rate was 14.7% and on oasis unit was 8.72% in November 2015. The RN vacancy rate in endoscopy was high at 20.7% as was the unqualified vacancy rate on CAU at 31.9%

Medical staffing

- Consultant cover was provided for CAU and oasis unit between 8am and 5pm at Rochdale Infirmary. Junior doctors were on site 24 hours a day, seven days a week.

Senior support was available via the duty medical registrar based at Fairfield General Hospital outside of core consultant hours.

- Between October 2014 and March 2015 there was a high rate of locum usage on CAU. Fifty-nine percent of medical staffing was provided by locums.
- There were two permanent consultants in post. Junior doctor cover was usually provided from the GP rotation training scheme, however at the time of our inspection, three of these posts were covered by locum staff. Data provided by the trust showed that the medical staff vacancy rate on CAU and oasis was 100%
- There were local induction processes for locum doctors. Locum medical staff told us that induction processes were good; they felt well supported and were offered training.

Major incident awareness and training

- There was a trust wide business continuity plan in place to ensure services could continue to run in the event of staff shortages, equipment failure or a major incident.
- There was no additional bed capacity for winter pressure use at Rochdale Infirmary.

Are medical care services effective?

Good

We rated effective as good because;

- Care and treatment was delivered in line with national guidance and best practice. Locally produced guidelines reflected evidence based care and treatment. Patients were reviewed daily by consultants.
- Local audits were completed and the endoscopy unit was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- Pain was assessed and patients received timely pain relief. Patients had their nutritional needs assessed.
- The average length of stay was lower (better) than the England average and the overall risk of readmission was also lower.
- Staff were supported to develop their skills, but appraisal rates were low in some areas. Staff worked closely with other members of the multi-disciplinary team and with other agencies. Staff had access to the information they needed to provide effective care and treatment. They understood the Mental Capacity Act and deprivation of liberty safeguards and took consent appropriately.

However;

- However, performance on the national heart failure audit was poor in comparison the England average and care for this group of patients required improvement.
- There was access to diagnostic testing, but if this was required out of hours or at weekends patients were transported to other sites within the trust.
- Nurse led consent in endoscopy had not yet been implemented although this had been identified as an area for improvement in 2014.
- The bed rail assessment did not detail patient capacity to consent.

Evidence-based care and treatment

- Care and treatment was delivered in line with national guidance from NICE, the Royal College of Physicians (RCP) and Royal College of Nurses (RCN) along with locally produced guidelines. Daily consultant led ward rounds were completed on CAU and oasis unit.
- The surviving sepsis campaign guidelines were followed in the trust's management guidelines, including implementation of the sepsis six care bundle along with guidelines for ongoing management.
- Patients received an assessment of their risk of a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality statement (QS) 66. There was a trust wide audit programme covering compliance with NICE quality standards and guidance.
- In endoscopy, procedures were carried out in line with professional guidance produced by NICE and the British Society of Gastroenterologists.

Pain relief

- There was a quick reference flowchart to guide decisions about pain assessments and pain relief. There were guidelines on the intranet for the management of acute pain and a care plan for pain.
- During intentional rounding, patients were asked if they required pain relief. Patients who required pain relief were prescribed appropriate medication.
- Sedation was used in endoscopy in line with best practice.
- The oasis unit had been involved in the trial of a new pain assessment specifically designed for patients with dementia. This assessment was an observational assessment tool that also allowed the patient's family to be involved.

Nutrition and hydration

- Patients received an assessment of their nutrition and hydration needs on admission. Nurses completed the malnutrition universal screening tool (MUST) and made referrals to dieticians when required. Fluid balance charts were in use when appropriate. There was access to speech and language therapists when patients needed a swallowing assessment.
- A coloured tray system was in place to highlight patients who needed assistance with eating and drinking. Patients were offered assistance when needed. Water jugs and cups were available at patients' bedsides.
- On the oasis unit, patients and their families had access to a small kitchen area to prepare hot and cold drinks and snacks.
- Patients were provided with drinks and snacks following procedures in the endoscopy unit.

Patient outcomes

- Medical services at Rochdale Infirmary had participated in the national heart failure audit. Other national audits were not relevant to this location due to the nature of the patient groups treated at this site.
- In the 2013/14 heart failure audit, the hospital scored worse than the England average for three out of the four clinical (in-hospital) indicators and for six out of the seven clinical (discharge) indicators. Results were particularly low for the outcomes relating to input from a specialist and cardiologist (15% and 9% compared to the England average of 78% and 60%). They were also low for the indicators to show if patients were discharged on suitable medication. For example, none of the patients included in the audit were prescribed a beta-blocker on discharge as compared to the average of 85% and low numbers of patients were prescribed other medications to lower blood pressure. There were low numbers of admissions (48) for patients with heart failure, however this aspect of the service required improvement. We saw that the hospitals performance in relation to care for patients with heart failure was being regularly monitored by the North West Advancing Quality programme but that performance continued to be low.
- The overall relative risk of readmission at Rochdale Infirmary was lower than the England average, although patients under the care of respiratory medicine had an elevated risk.

- The endoscopy unit was accredited by the Joint Advisory Group on GI Endoscopy (JAG). JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards. The unit had been visited in November 2014 and a report prepared with recommendations. All of these recommendations had been implemented in order to maintain JAG accreditation, however there were still issues regarding the waiting list for endoscopy at Rochdale Infirmary.
- The endoscopy unit had adapted the World Health Organisation safer surgery checklist and were trialling this on site.

Competent staff

- Staff told us that individual performance reviews (IPRs) were conducted annually with reviews of progress held on a six monthly basis. However, data provided by the trust showed that only 76% of staff on CAU and the oasis unit had received an up to date appraisal. In endoscopy this fell even lower to 58% of staff.
- Health care assistants were also encouraged to complete a three day course giving them the skills and knowledge to take patient observations. Nine HCAs in medicine across the trust had completed the care certificate.
- Staff on the oasis unit had attended a two day dementia course run by the rapid assessment, interface and discharge (RAID) team.
- There were nurse endoscopists who were trained to complete both upper and lower gastrointestinal endoscopies.

Multidisciplinary working

- There was evidence of partnership working with the local mental health trust to deliver services for those patients with mental health, drug or alcohol issues. The RAID team visited inpatients to provide assessment, advice and intervention.
- Staff on the oasis unit worked very closely with colleagues from the mental health trust. Documentation including risk assessments and recommendations completed by the mental health nurses was available on the ward for Pennine Acute staff to view.
- CAU and oasis had access to other members of the multi-disciplinary team such as occupational therapists, physiotherapists and social workers. We saw evidence in medical records that referrals were made appropriately to these teams.

Seven-day services

- Consultant ward rounds were held daily on CAU and oasis unit.
- CT and MR scanning was available until 5pm on weekdays and plain film x-ray were available until midnight. There was no facility for CT or MR scanning and weekends. If diagnostic imaging was required outside of the hours provided, patients were transported to other sites within the trust.
- The endoscopy service was provided Monday to Friday. There were occasional lists on Saturdays run as part of waiting list initiatives. Manometry was only provided Monday to Friday.
- Emergency endoscopies were carried out at other sites within the trust but staff based at Rochdale Infirmary contributed to this rota.
- There was a registered mental health nurse available for advice Monday to Friday. Outside of these hours the RAID team at other sites was used.

Access to information

- Staff had access to the information they needed to provide care and treatment to patients. Records were available on the ward and there were sufficient numbers of computers to allow access to test results and trust policies and procedures.
- There were folders available on the wards to provide additional information to support the delivery of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was taken from patients attending endoscopy on the day of the procedure. Patients told us they were given sufficient information about the procedure and time to ask questions. Staff told us that nurse led consent was being considered in endoscopy. We noted that this was being considered at the time of the JAG accreditation visit in August 2014 and that this had still not been implemented.

Medical care (including older people's care)

- An audit of consent was undertaken across the trust. The most recent audit had showed that an incorrect consent form four was being used. Actions were identified and had been completed to deal with this error.
- There was an enhanced observation policy place for patients requiring additional supervision. This contained clear guidelines on risk assessments for this patient group and procedures to follow if a patient required additional observation or one to one care. There were care plans for patients receiving enhanced observation and logs to be completed. We saw that emergency and standard deprivation of liberty safeguard (DoLS) applications were made for patients receiving one to one care in line with this policy.
- Staff understood the mental capacity act and what constituted deprivation of liberty. We saw evidence that deprivation of liberty applications had been made appropriately for patients on the oasis unit. Documentation was complete and contained capacity assessments and applications for both urgent and standard DoLS.
- Although the bed rail assessment prompted nurses to consider mental capacity, it was not documented on the assessment. Capacity should always be considered when using bed rails as this could be judged a deprivation of liberty.

Are medical care services caring?

Good

We rated caring as good because;

- Staff were kind, caring and compassionate. They maintained the privacy and dignity of patients in their care.
- Patients were cared for in an individualised way of the oasis unit and their carers and families were encouraged to be involved in their care. Patients were given enough information about care and treatment and had time to ask questions.
- Friends and family test results showed that 97.5% of patients would recommend medical services at Rochdale Infirmary. Open visiting was in place and there was access to specialist mental health services.

Compassionate care

- Patients were complimentary about their treatment and told us that care was good. They described staff as very friendly.
- We observed staff interacting with patients in a caring and compassionate way. They ensured that privacy and dignity was maintained. Staff on the oasis unit treated each patient as a unique individual. Staff took time to find out about their individual needs and preferences and tailored activities around the patient.
- Staff were kind, patient and considerate of people's needs. They were sensitive and supportive in their communication with patients.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.
- Friends and Family test results for CAU between September 2015 and February 2016 showed that 97.5% of patients would recommend the service.

Understanding and involvement of patients and those close to them

- Patients were involved in decisions about their care. Staff ensured information about care and treatment was provided and understood. They gave additional support or time when needed. We observed patients and their carers being given information about their care and treatment and offered time to ask questions.
- Patients told us that staff explained care and treatment and that they were given time to ask questions. On the oasis unit, families and friends were encouraged to be involved in the loved ones care and treatment.
- Patient information leaflets were available**.** In endoscopy, there were leaflets explaining each type of procedure offered.

Emotional support

- Open visiting was in place on the oasis unit to allow carers and family members to offer additional emotional support whilst their loved one was in hospital. Family members were also able to stay overnight.
- There was access to mental health nurses from the local mental health trust on the oasis unit for additional specialist support.

- Chaplaincy services were available for patients and relatives Monday to Friday and also access urgently out of hours.

Are medical care services responsive?

Good

We rated responsive as good because;

- Services at Rochdale Infirmary had been planned to meet the needs of local people, although they did not provide a full range of specialist services. Ambulatory care was available seven days a week, reducing the need for patients to be admitted to hospital.
- Referral to treatment times for the trust for admitted (adjusted) patients were above (better than) the England indicator and England average.
- The specialist oasis unit was thought to be the first of its kind in a hospital in England. This type of unit is an example of outstanding practice.
- There were clear admission and discharge processes in place and a transfer of care team was available to support with more complex discharges.
- The oasis unit was designed to be dementia friendly. The unit reflected the needs of patients living with dementia and staff delivered patient-centred care. There was a trust wide dementia strategy and a nurse consultant in dementia care. Patients with a learning disability were identified and there was a learning disability specialist nurse.
- Patients were given information about how to make a complaint. There had been four complaints about medical services at the hospital between 1 December 2014 and 31 December 2015. Complaints were discussed at clinical governance meetings and a quarterly learning from experience was sent to the trust board.

However;

- Bed occupancy rates were high at around 93% and there was sometimes a waiting list to access the oasis unit.

Service planning and delivery to meet the needs of local people

- Patients told us that medical services at Rochdale Infirmary were convenient. Patients had to travel to other site within the trust to access more specialist care acute care. This decision had been made to ensure sustainability of services and work as part of the Greater Manchester's healthier together programme was ongoing.
- CAU offered an ambulatory care service seven days a week for patients with deep vein thrombosis (DVT), although ultrasound scanning was only available Monday to Thursday. From Friday to Sunday, patients were referred to an alternative hospital for ultrasound scanning.
- A business plan had been developed to provide a district wide manometry service as referrals for these investigations had increased. This included moving the service into a more suitable environment and increasing clinic capacity.
- The oasis unit had been developed following recognition that patients with delirium or living with dementia were not receiving patient centred care on CAU. This unit was developed as a pilot initiative and had been a well utilised and beneficial unit for this patient group. There was a recognised need for additional capacity within this unit and a further five beds were planned.

Access and flow

- There was a clear admission process in place for CAU and the oasis unit. Referrals were taken via the GP, urgent care centre or from other hospital site within the trust. The nurse in charge co-ordinated the admissions process.
- The average length of stay for elective admission in general medicine was 1.2 days which was lower (better) than the national average of 4.7 days. This was also the case for non-elective admissions, were the average length of stay was 3 days compared to the England average of 6.4 days.
- There was a daily meeting with the transfer of care team to discuss complex discharges. The team on CAU worked closely with GPs and had good arrangements in place for admissions and discharges.
- CAU had access to a private ambulance. This allowed them to co-ordinate admissions and discharges in an efficient and timely way, improving patient flow through the ward.
- Referral to treatment times for the trust for admitted (adjusted) patients were above (better than) the England indicator and England average.

Medical care (including older people's care)

- Between November 2014 and October 2015 only 2% of patient moved ward twice or more. There had been 36 moves at night on CAU and one on the oasis unit. Trust policy was that patients should not be moved between 8pm and 8am.
- On CAU the bed occupancy rate was 93.2% between October and December 2015. On the oasis unit the bed occupancy was 93.3%. When bed occupancy rates are above 85% it can affect the quality of care provided.
- The average length of stay on the oasis unit was 7 days, although patients with more complex needs stayed longer. At times there was a waiting list to access the oasis unit.
- The endoscopy unit was unable to run to full capacity due to a shortage of nursing staff. At the time of our inspection the unit was operating on 3 ½ days per week, despite funding for 4 ½ days.
- There were plans to increase the capacity in manometry. At the time of our inspection there were waits of up to 10 weeks for this investigation.

Meeting people's individual needs

- The oasis unit offered a dementia friendly environment. There were dementia friendly signs and reminiscence areas. Families were encouraged to bring in personal items belonging to patients to create a more home like environment. Staff had access to a range of activities to share with people living with dementia and tailored these activities to each individual patient. The unit had invested in 'pop up' reminiscence rooms depicting various environmental scenes for example, a pub, a garden and a cinema, to provide calming and therapeutic environments. A reminiscence tablet had also recently been provided and staff were awaiting training in order to use this. Volunteers were also used on the oasis unit to support staff in delivering person-centred care.
- Open visiting was in place and families were able to stay overnight with their relative. There was a small kitchen area for patients and their families to use. Patients were able to use this kitchen to prepare their own drinks. The kitchen area could be locked for safety reasons if necessary.
- The EPR system alerted staff to cognitive impairment, including dementia. The system automatically sent a safeguarding referral if assessments such as the abbreviated mental test indicated cognitive impairment.
- Across the trust 5982 patients with dementia were admitted last year. There were 125 inpatients with dementia at any one time. There was a dementia nurse consultant in post for the trust and a dementia strategy in place. Assessments of dementia were completed in line with national guidelines. The 'find, assess, investigate, refer, inform' criteria were used alongside assessments such as the abbreviated mental test and the confusional assessment method. We saw the "This is me" document in use on the oasis unit. Monthly audits were completed to ensure patients were being screened for dementia. An annual survey for carers of people living with dementia was undertaken. The trust was planning to participate in the 2016 dementia audit.
- There was a flagging system in place for patients with a learning disability. Information was shared between local community and mental health trusts. An email automatically generated and sent to the LD liaison nurse. Across the trust last year, 783 patients with a learning disability were admitted. A traffic light passport was used. The care provided to patients with a learning disability was audited in line with the trust wide Learning Disability Quality Assurance Framework.
- Translation services were available via a bank of 107 interpreters. The most requested languages were Urdu, Punjabi, Bangla and Polish.
- There were no mixed sex breaches in medical services at Rochdale Infirmary between December 2014 and November 2015. Staff had considered the need for single sex facilities in endoscopy and there were separate admission areas for males and females.
- On CAU, staff identified that the design of the ward places the privacy and dignity of female patients at risk. To access the female bathroom, patients were required to walk through the ward past male bays and nursing stations.
- The manometry room was cramped and it would be difficult for patients with mobility difficulties or who were wheelchair users to access this service.
- One patient told us there was little to do on CAU and would have liked a television or radio to relieve boredom. We noted that this had been highlighted on the quality board from previous patient feedback.

Learning from complaints and concerns

- Leaflets explaining how to raise a complaint or concern were available in waiting areas.

Medical care (including older people's care)

- There were four complaints about medical services between 1 December 2014 and 31 December 2015. Two of these complaints were closed and had taken 82 and 131 days until they were resolved which was longer than the overall trust average time of 77 days to close complaints. Complaints and learning from complaints was discussed at governance meetings.
- A quarterly learning from experience report was sent to the trust board. This included details of complaints and contacts through the patient advice and liaison service (PALS) identifying themes and trends.

Are medical care services well-led?

Good

We rated well led as good because;

- Staff were aware of the trust vision and values. There was a service improvement plan in place for the division of integrated community services.
- There was an established governance structure in place that fed back into the overall governance system for the trust. The risk register was up to date and detailed actions taken to reduce identified risks.
- Leaders were visible and staff felt supported by them. They felt there had been a positive change in the overall leadership of the trust in the past 18 months.
- Staff described the culture as friendly and supportive and they were proud of the services they provided. Staff meetings were held regularly and success was celebrated through weekly communications from the chief executive and annual staff awards.
- Staff had been involved in the development of the trust vision and values and the "healthy, happy, here" programme of work.
- Leaders were supported to be innovative in the way they worked and were able to give examples of changes they made to improve services for patients such as an onsite blood laboratory and an onsite doppler service. The oasis unit was being expanded by a further five beds following a successful pilot of this specialist dementia ward.

However;

- Although there were open and honest care boards detailing actions taken from patient feedback, there had been no local patient surveys carried out recently.

Vision and strategy for this service

- Staff were aware of the trust values. There was a trust transformation map that set out the vision for the future up to March 2020. Trust values were prominently displayed in all areas we visited. The trust's vision was to be a leading provider of joined up healthcare that would support every person who needed services, whether in be in or out of hospital, to achieve their fullest health potential. The values were to be quality driven, responsible and compassionate.
- There was a service improvement plan in place for the division of integrated community services.

Governance, risk management and quality measurement

- Medical services was managed within the division of integrated and community services. The division held monthly governance meetings to discuss governance, risk and quality. This was fed back into trust quality and performance meetings.
- A weekly senior team meeting was held with a standard agenda covering areas such as incidents and complaints.
- The divisional management team held locality planning board meetings which included external stakeholders such as clinical commissioning groups and a local charity. The management team valued these.
- There was a new risk management strategy being implemented in the trust. A new risk register was in place that identified a number of risks, including the use of locum medical staffing and the risk of failing to achieve advancing quality measures. We saw that there were controls in place to minimise these risks and that action plans were in place to reduce these risks further, with agreed timescales for review.
- Safety issues were highlighted to staff through weekly 'Spotlight on Safety' newsletters from the chief executive officer and the quarterly 'Pride in Safety' newsletters. The winter 'Pride in Safety' newsletter identified that its aim was to share learning across the organisation.

Leadership of service

- Staff told us the senior managers visit wards and listen to staff ideas to develop services. Staff at all levels spoke highly of the support provided divisionally.

- Leaders felt they were supported to be innovative in the way they developed services and had clear ideas to make improvements.
- Staff told us that there had been a positive change in the overall leadership of the trust in the past 18 months. They spoke highly of the Chief Nurse and Deputy Chief Nurse and felt that the trust had moved in a positive direction since their appointment. They talked about changes made for the better and a drive to improve.

Culture within the service

- Staff described the culture as friendly and supportive. They were proud of the services and care they delivered.
- There was a booklet celebrating successes across the trust, including achievements and developments at Rochdale Infirmary. In addition to this, the Monday message from the chief executive highlighted examples of good care and practice.
- Sickness rates for medical services at Rochdale Infirmary averaged 4.6% for the eight months up to December 2014. Sickness rates for unqualified staff were high at 10.9%. Staff told us they were well supported during periods of illness and absence. They felt supported to return to work. When possible staff were able to return to work with adjustments made to their working hours or duties.
- The latest staff friends and family test results for January 2016, show that 70% of staff would recommend the hospital as a place to be treated. 57% of staff would recommend the hospital as a place to work.

Public engagement

- There were open and honest care boards including "you said, we did" information displayed on each ward. These boards displayed comments received from patients and planned or actual changes made as a result of these.
- There had not been any patient or public surveys carried out for medical services at Rochdale Infirmary.
- The endoscopy unit had carried out a patient survey in 2013. We saw that any negative patient feedback was dealt with via an action plan. The survey had revealed a need for consent to be taken outside of the procedure room and during our inspection, senior nurses confirmed that there were two designated pre-procedure consent rooms. A rapid improvement group to improve endoscopy services included patient representatives.

Staff engagement

- Regular, minuted staff meetings were held. Some staff met with colleagues who were based on other sites when this was appropriate for the service or clinician.
- There were weekly emails from the chief executive and listening in action events.
- In 2014, the 'chief executive's challenge' was introduced. Staff were asked to be involved in developing the trust vision and values. This challenge received 27,000 ideas from the workforce. Staff had also been asked to give their views on reducing staff sickness absence rates. The development of the trusts "healthy, happy, here" programme was the result of the 44,000 contributions. The third challenge had recently been completed and led to the development of the 10 "raising the bar on quality" actions.
- Staff awards were held annually, recognising team and individual staff patient care, dedication and innovation.

Innovation, improvement and sustainability

- The oasis unit had been developed as a pilot project. This was believed to be the first specialist unit of its kind in a hospital in England. Following a successful evaluation of this service, the ward was to move with the addition of a further five beds.
- Leaders on CAU had recognised ways to improve patient experience and patient flow and gave examples of how the service had been innovative. For example, the introduction of a blood laboratory onsite, outsourcing ultrasound doppler scanning and the use of specific ambulance transport services to transport patients to be admitted or discharged in a timely way.
- The team at Rochdale Infirmary were working to improve local healthcare services in partnership with many local stakeholders including the GP federation, local authority, the CCG and charitable organisations.

Surgery

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

Information about the service

Rochdale Infirmary is the smallest hospital run by the Pennine Hospitals NHS Trust. It is situated close to Rochdale town centre and lies 14 miles northeast of Manchester.

Rochdale Infirmary provides a range of hospital services including a 24/7 Urgent Care Centre (UCC), short stay inpatient Clinical Assessment Unit, oasis Unit for acute medical patients with dementia, a specialist Pennine Rheumatology Centre, x-ray and blood testing, antenatal services, early pregnancy unit, outpatient clinics, and a new specialist Eye Unit. We were told that 13,100 patients had attended the day surgery unit from July 2014 to June 2015.

During our inspection, we visited five theatres, two recovery wards and the ophthalmic ward.

We spoke with three medical staff, 11 nursing staff including managers, two members of the multi-disciplinary team, six patients and one family member.

Summary of findings

Overall, surgical services were rated good.

We found that surgical services were safe, effective, caring, responsive and well led.

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident management was in line with 'being Oopen' and the 'duty of candour.'
- The 'duty of candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Care was provided in line with NICE CG50. Patient's risks were assessed to determine their fitness for surgery.
- Only lower risk patients were identified to proceed with surgical treatment at this hospital site.
- The service had protocols and guidelines in place to assess and monitor patient risk in real time. Should a patient deteriorate staff would dial 999 and arrange for the patients transfer to a hospital, which provided an inpatient facility.
- Systems were in place to ensure that risks to elective and emergency patient groups were identified pre-operatively, for example, venothromboembolism

Surgery

(VTE) assessment was completed for all hospitalised patients within 24 hours of admission. Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.

- We observed good infection prevention practices by staff and noted good compliance in this area.
- Equipment tests had taken place with the exception of a blood pressure machine, which was immediately removed from use. Daily monitoring of resuscitation equipment had taken place. However, we observed that three pieces of the resuscitation equipment had no expiry dates on the packaging or identified on the resuscitation checklist. This finding was immediately escalated to the nurse in charge.
- We observed high levels of staff attendance at training sessions, 100% of day surgery nursing staff had completed mandatory training. Training statistics for 2015 – 2016 confirmed compliance of 92% or more for nursing and medical staff groups who had completed level two safeguarding of vulnerable adults training. However, we observed shortfalls in staff attendance at sepsis training.
- Consent processes were generally robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Medical and nursing staffing levels and skill mix was recognised as being safe and reflected current guidance. Operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations.
- There was good access and flow within the service and people's needs were being met. Service developments had improved patient access to treatment through the introduction of new elective lists.
- Patients received evidenced based care and treatment and patient outcomes were good. Good multi-disciplinary working existed between the trust, surgical day service, local clinical commissioning group and community services.
- Staff were caring, compassionate and respectful. Staff were positive about working in the service and described a culture of flexibility and commitment.
- The service was well led and a clear leadership structure was in place. Individual management of the different areas were well led. New governance and risk management processes and leadership were in place. This meant that learning and monitoring processes from audits may not be as robust as they should be.
- Feedback from staff and patients had resulted in changes to aspects within the service.

However

- We observed that three pieces of the resuscitation equipment had no expiry dates on the packaging or identified on the resuscitation checklist. This finding was immediately escalated to the nurse in charge.
- Patient records on the day surgery unit were observed to be in an open top records trolley, which did not ensure their security.
- Discussions with some staff showed that they did not understand the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards, which could affect the support they provided to patient groups.l

Surgery

Are surgery services safe?

Good

Surgical services at Rochdale Infirmary were found to be good.

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident management was in line with 'being open' and the 'duty of candour.' The 'duty of candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Care was provided in line with NICE CG50. Patient's risks were assessed to determine their fitness for surgery. Only lower risk patients were identified to proceed with surgical treatment at this hospital site. The service had protocols and guidelines in place to assess and monitor patient risk in real time. Should a patient deteriorate staff would dial 999 and arrange for the patients transfer to a hospital, which provided an inpatient facility.
- Systems were in place to ensure that risks to elective and emergency patient groups were identified pre-operatively, for example, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.
- We observed good infection prevention practices by staff and noted good compliance in this area.
- We observed high levels of staff attendance at training sessions, 100% of day surgery nursing staff had completed mandatory training. Training statistics for 2015 – 2016 confirmed compliance of 92% or more for nursing and medical staff groups who had completed level two safeguarding of vulnerable adults training. However, we observed shortfalls in staff attendance at sepsis training.
- Medical and nursing staffing levels and skill mix was recognised as being safe and reflected current guidance. Operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations.

However we also found:

- Equipment tests had taken place with the exception of a blood pressure machine, which was immediately removed from use. Daily monitoring of resuscitation equipment had taken place. However, we observed that three pieces of the resuscitation equipment had no expiry dates on the packaging or identified on the resuscitation checklist.
- Patient records on the day surgery unit were stored in an open top records trolley, which did not ensure their security whilst on the ward area.
- Access to open clinical waste bins and into the theatre areas was noted because the door leading from the clinical waste storage room to the external clinical waste storage area, which was locked, was left open.

Incidents

- Systems were in place to ensure incidents were reported, investigated and lessons learnt.
- Data from STEIS (December 2014 – November 2015) confirmed no serious incidents were reported in the day surgery service at Rochdale Infirmary (RI). This was confirmed at inspection during discussions with the trust governance team.
- Between 1 December 2014 and 30 November 2015, a total of 106 incidents were recorded for the Rochdale Infirmary hospital site. Each incident identified the impact associated with the incident. The majority of incidents were graded as no harm incidents. The main themes related to patient documentation; 49 documentation incidents were recorded which included unavailability of patient's records (13 incidents), missing investigation reports (three incidents) and medical records misfiled (three incidents). Staff told us that an open culture existed for incident reporting.
- Medical and nursing staff told us they knew how to report incidents and received feedback from incidents through staff meetings, at the daily huddle and by email. Quality and performance and board meetings were also forums were incidents and significant events were discussed.
- Staff told us that safety alerts were circulated via email, the general manager and risk department; relevant alerts were discussed at the directorate governance meeting.
- The trust 'Incident Reporting & Investigation Policy including Serious Incident Framework and Duty of

Candour (EDQ008)' was in line on 'being open' and the 'duty of candour.' The 'duty of candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Following the launch of the new incident policy in 2015 a power point presentation and frequently asked questions document for staff was circulated trust wide.

- We spoke with five staff about the 'duty of candour' regulation; three staff members demonstrated some knowledge about this regulation.
- Mortality and morbidity review meetings are a forum where in-hospital deaths are reviewed. Staff told us that mortality reviews had been introduced and that mortality and morbidity meeting minutes were now being documented, the findings discussed at the safety committee. We saw discussions and learning relating to mortality and morbidity in the minutes from the trust wide 'Upper GI/Colorectal Surgery Governance/Clinical Audit Meeting (23 September 2015).'
- The December 2015 'Integrated Performance Report', identified mortality rates were relatively good. The trust's service hospital mortality indicator (SHMI) remained above 1.00 and is within the expected range. Hospital standardised mortality rates (HSMR) were noted as good compared to peers (3rd best in the North West).

Safety thermometer

- The NHS safety thermometer is a national initiative, which uses a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. It provides a monthly snapshot audit of avoidable harm including falls, new pressure ulcers; catheter related and urinary tract infections (CUTI). The Care Quality Commission pre-inspection document for surgical services across the trust (January 2016) summary of analysis identified a steady rise in the number of pressure ulcers, four per month, reported between December 2014 and March 2015 and in December 2015. Low numbers of falls with harm were reported averaging two per month, whilst catheter acquired infections averaged one per month. We requested safety thermometer data for the last three months; however, the data we received provided no information relating to surgical services at the Rochdale Infirmary site.
- The trusts December 2015 'Integrated Performance Report' confirmed that the highest priority trust wide harms were pressure ulcers and falls. A pressure ulcer reduction action plan is in place and 'falls' now feature in the trust safety programme.
- The trust confirmed that a venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%. Elective surgical patients were risk assessed pre-operatively using the peri-operative assessment document. The assessment was re-reviewed on admission. We reviewed two patients' peri-operative documents and saw that VTE assessments had been completed for them.
- Patient safety is overseen by the patient safety team whose safety programme focused on the profile of incidents and complaints and whether the early warning score featured in the incident.

Cleanliness, infection control and hygiene

- The day surgery unit (DSU) had an infection control 'link' staff member. Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available.
- Good infection control practices were observed by staff throughout the DSU and theatres. We observed the use of personal protective equipment and hand sanitiser by staff. Hand sanitiser was located on entry to each clinical area and within the clinical areas. All staff were observed complying with the bare below the elbows policy.
- Staff received infection prevention and control training as part of their induction and annual mandatory training. Staff confirmed completion of yearly on line infection control training. The service training statistics for 2015 - 2016 confirmed that 91% of nursing staff had completed infection prevention (non-patient handling) training. Whilst, infection prevention (patient handling) training attendance figures showed attendance by 80% - nursing and midwifery staff and 82% -medical and dental staff.

- Cleaning schedules identified the tasks and frequency of cleaning in each area. We saw two cleaning schedules one related to daily checks, the other weekly checks. These schedules were completed with signatures and dates to confirm the respective tasks were done.
- We observed that the service had adopted the 'National Colour Coding Scheme' for hospital cleaning materials and equipment. For example, linen codes were, red for infected and contaminated linen, white for soiled linen and green for theatre linen.
- Guidance was available for staff on blood spillages and staff told us that a blood spillage kit was available to use to clean up such spillages.
- Monthly environmental cleaning score audits for nurse, midwife and healthcare assistants (HCA) had taken place throughout 2015. The minimum average target for the trust and per site was 88.6%, which is a green status. The trust environmental audit report (SUR8) identified cleaning scores for nursing, midwives and HCA staff at Rochdale Infirmary as 97%, which was an increase of 5% on September 2015. Data provided from April 2014 until October 2015 for Rochdale Infirmary confirmed ongoing green status with monthly cleaning scores from 93% to 98%.
- The monthly cleanliness scores for computer equipment at Rochdale Infirmary from April 2014 to October 2015 had an identified green status, with one exception in October 2014 when the score was identified as 67%. However, the monthly breakdown of information pertaining to theatres, the eye day unit and day surgery confirmed that compliance was mainly at 100% for these areas over 13 months. The only exception was in September 2015 the eye day unit was awarded a cleaning score of 87%.
- 'Infection prevention – an information guide' (February 2014) is a leaflet available for patients and visitors. The leaflet informed patients of the measures to take to prevent infection. Details of what to expect from staff's infection prevention practices were identified for patients. The leaflet was available in English but could be obtained in other languages; details of how to obtain it in another language were included within the leaflet.
- Senior staff told us that the trust had focused on sepsis management and training. In June 2014, the trust had reviewed the sepsis policy which was discussed it at the patient safety programme board in January 2016. Following this, an improvement plan was developed which included the development of online sepsis training. To-date, 4% of nursing and midwifery staff had completed sepsis training for 2015 – 2016.
- Pre-operative assessments of patients took place approximately 12 weeks prior to scheduled surgery. Multi resistant staphylococcus aureus (MRSA) screening was performed at the pre-assessment appointment.
- We asked whether there had been any MRSA, Clostridium Difficille or surgical site infections in the Rochdale surgical service during the past six months and were told there had been none.

Environment and equipment

- Equipment suitable for patients was seen in all clinical areas.
- Equipment had stickers with dates confirming that maintenance checks had taken place. However, one piece of equipment, a blood pressure machine's last maintenance check was dated the 16 April 2012; this was escalated to the ward sister and the machine removed from use.
- Resuscitation monitoring records confirmed that resuscitation equipment was checked daily. However, staff told us that the resuscitation trolleys had just been introduced a week previously, despite previous requests for new resuscitation trolleys.
- We observed three pieces of resuscitation equipment had no expiry date identified. This equipment was a pocket mask, ambu bag and oxygen tubing and a high concentration device. The ambu bag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately. The equipment, which had no expiry dates, was identified to the nurse who escalated this to a trust assistant resuscitation officer.
- Prior to their appointment patients could book a hospital wheelchair to assist them with their mobility.
- The bronchoscope on the difficult intubation trolley was out of date. This was escalated to the theatre lead who had it removed for cleaning.
- Staff told us that anaesthetic equipment had been standardised across the trust. We observed that the anaesthetic equipment at Rochdale Infirmary was new and followed the appropriate guidance. We saw the checklist book for the anaesthetic machines and saw that they were checked each working day before use.

- Clinical waste for the day surgery unit was stored in unlocked clinical waste bins located inside a designated room, which was accessed by a swipe card. The external clinical waste bins were accessible from an unlocked door leading directly from this room to an external storage area, which was locked. The external clinical waste bins were locked. We observed the door leading from the building should have been locked which was confirmed by a notice attached to the door. The unlocked door was escalated to the unit manager who said they had an ongoing problem with staff not locking the door. Following this incident, the unit manager completed an incident form to report the unlocked clinical waste room door.
- Gas cylinders were stored inside the building within a designated area. Full and empty gas cylinders were stored separately. Staff told us that empty gas cylinders were collected and replaced by an identified provider. We also checked an external building, which housed gas cylinders and saw that it was locked.
- Theatre equipment was sterilised at Oldham Hospital and transported to Rochdale Infirmary. Staff told us that adequate equipment supplies were provided and in the event that there was a shortage of equipment, they asked other hospital sites to provide the necessary equipment. Staff said that this system worked well and that to date they had no problems sourcing sterilised equipment in this way.
- Security was maintained by the use of keypad entries into the ophthalmic and day-case theatres at Rochdale. In the evening, the main door into the day surgery unit was locked and would be opened by staff.

Medicines

- Medicines management was in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys. We reviewed three patients' drug charts and no gaps were seen against the entries.
- The policy for the ordering, storage and administration of controlled drugs (CD) (EDC017) had expired on the 1 February 2016; its review date was identified as the 1 August 2016. Normally the review date is identified before the expiry date.The trust confirmed a new policy had been ratified and was to be uploaded to the trust document management system. The trust confirmed a new policy had been ratified and was to be uploaded to the trust document management system.
- The CD policy identified daily CD checks. We reviewed the CD book and saw that daily checks of controlled drugs had taken place.
- A dedicated pharmacist and pharmacy was located on site to provide support for the surgical day unit. Pharmacy supplies in the main theatres are managed through a top up system. Pharmacy stock for the eye theatre was managed by staff who ordered medications when supplies fall.
- We were told that nursing staff dispensed patients discharge medication from the ward stock to assist with patient discharge and patient flow.
- We saw patient group directives (PGDs) for the administration of instillagel, which is a local anaesthetic, and for tefracaine 4% gel, which is a topical anaesthetic cream. Both PGD's were version controlled and dated.
- Nursing and medical staff received medicines management training at induction. Training statistics provided by the trust for Rochdale theatres confirmed that 28 staff had completed medicines management training against a target of 30 staff. Four of the nursing staff within the eye ward at Rochdale had completed medicines management training against a target of five staff.
- A trust wide antimicrobial point prevalence study was completed in July 2015. The outcome showed that antimicrobial prescribing within the trust was good. Three work streams were identified which included a repeat of this audit in January 2016. However, the audit had not involved the surgical services at Rochdale Infirmary.

Records

- Computerised patient records were password protected and staff had individual passwords to allow them to access patient information.
- Patient's records were kept in an open trolley on the day surgery unit (DSU). Staff told us that the storage trolley containing the patient records was not always observed by staff, which meant records were not stored securely on the ward area. When the day surgery unit was closed patient records were stored in the reception office, which we saw, was secure when not in use.
- We reviewed a mixture of seven sets of medical and nursing notes. We observed completed pre-operative assessments, pre-operative checklists, consent

documentation, correct site surgery sheets, perioperative records, surgical safety checklists, post-operative care records and discharge dates and times logged for those patients discharged home.
- Risk assessments where relevant were completed, for example, four patients records showed pressure area and venous thrombus embolism (VTE) assessments were completed.
- In line with the Royal College of Surgeons 'Good Surgical Practice (2014) staff told us that pre-operatively patient concerns and / or needs were discussed with the multi-disciplinary team including the patient's surgeon at the patient's pre-admission visit. For example, a patient with safeguarding needs or complex needs would be identified prior to surgery so that the necessary support could be identified for that patient.
- Staff completed the '5 steps to Safer Surgery' World Health organisation (WHO) surgical safety checklist for patients prior to and following surgical intervention. We reviewed three surgical safety checklists for patients and saw they were fully completed. The checklists were completed and recorded on-line and on paper in patient notes.
- The trust confirmed that patient's records audits had taken place across the surgical service. We reviewed one records audit a 'Trust-wide re-audit of Anaesthetic Record Keeping 2014' that showed shortfalls in documentation for Rochdale Infirmary. The trust target included the review of 30 sets of notes per hospital site; at Rochdale Infirmary 32 cases were reviewed which included eight major and 24 minor cases.
- The recommendations from this audit included, the current anaesthetic record should be reviewed against the requirements of the trust essential record keeping standards, and amended as necessary. Education around the importance of good quality record keeping, particularly in terms of protection in terms of medico legal cases. An action plan to be developed at the Clinical Audit & Governance meeting. The quality improvement action plan provided by the trust did not identify Rochdale Infirmary, as a site where improvements were required.

Safeguarding

- A trust safeguarding team advised on adults safeguarding concerns. The safeguarding team identified nursing staff for specific areas, for example, adult safeguarding, Deprivation of Liberty safeguards, dementia, learning disability and tissue viability.
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide and locally. The annual safeguarding adults and children report (2014 to 2015) provided assurance to the trust board that the necessary safeguarding framework was in place and continued to develop to ensure that the welfare of children and adults at risk was promoted and protected within the trust. This report also ensured that the trust continued to fulfil its statutory obligations in relation to safeguarding.
- Staff told us they had effective working relationships with the local adult safeguarding teams and other healthcare professionals such as social workers and community nursing staff.
- Staff demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised.
- Staff told us that concerns about safeguarding issues were also recorded on the daily and weekly safety huddle documentation.
- Staff attended children's and adult safeguarding training, initially at trust induction and then during core mandatory training. Training statistics provided by the trust confirmed that one nurse in the day surgery and oral surgery departments and four nurses in Rochdale theatres had completed level three safeguarding training.
- Training statistics provided by the trust for nursing staff attendance at level two safeguarding training confirmed that 10 staff from the day surgery unit and 33 staff from the theatres had completed this training. We observed that the training targets identified for each area had been exceeded. The training statistics for 2015 – 2016 confirmed that 93% of nursing and midwifery staff and 92% of medical and dental staff had completed level two adult safeguarding training.

Mandatory training

- We spoke with members of staff of all grades, who confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, resuscitation, fire safety, manual handling, infection control, and safeguarding.

- Internet based mandatory training included training sessions in fire awareness, basic life support and handwashing training sessions which were completed yearly by staff. In addition, other core mandatory training sessions included, information governance, equality and human rights, infection prevention for handlers, movement and handling for patient handlers and clinical waste segregation.
- Training statistics for Rochdale Infirmary day surgery unit confirmed 100% (15 staff) had completed their mandatory training until 23 February 2016.
- Training statistics provided by the trust confirmed that 84% of nursing and midwifery and 62% of medical and dental staff had completed basic life support training in 2015 – 2016. In addition, 25% of medical and dental staff had completed advanced life support training.

Assessing and responding to patient risk

- All patients saw their named consultant at each stage of their patient journey. Anaesthetists calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment of a patient about to undergo a general anaesthetic. The ASA was used for assessing the fitness of a patient before surgery and was based on six different levels with level one being the lowest risk. The hospital undertook procedures for patients graded as levels one to two. Staff told us that the patient group who received their treatment and / or surgery at Rochdale Infirmary were categorised as RSA 1 or 2 patients which meant they were fit and healthy patients
- Risks to patients were initially identified during their initial assessment by staff at either Royal Oldham Hospital or Fairfield Hospital and these needs identified within care plans and risk assessments.
- The service had identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level. Should a patient deteriorate staff would call 999 to arrange transfer of the patient to one of the inpatient hospital sites.
- Staff said they could access anaesthetists and surgical staff from theatres in the event of a patient deteriorating on the ward areas.
- The early warning score (EWS) is a tool used to monitor patients who may be at risk of deterioration by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. The tool is incorporated into the physiological observation chart with track and trigger early warning system scoring system guidance located on the back of the physiological observation chart. For those patients who had an early warning score above three and were awaiting urgent medical review this information would be communicated to staff coming on shift during the 'safety huddle' session at the start of the shift.
- During the theatre observations we observed staff completed the '5 steps to Safer Surgery' World Health organisation (WHO) checklist for patients, prior to and following surgical intervention. These checklists were recorded on-line and on paper in the patient notes. The staff involved were seen to stop, listen and were engaged in this process. We reviewed three checklists, which were seen to be complete.
- Senior staff told us that some recovery staff had completed either an external critical care-training course, in-house critical care course or recovery modules. Senior staff identified theatre recovery staff did not receive level three critical care training as a mandatory training requirement. If staff were nursing a level three patient in recovery an anaesthetist trained in level three care would assist with the patients care. A level three patient is a patient who requires advanced respiratory support alone or basic respiratory support together with support of at least two organ systems.
- Staff said that the last theatre case took place at 17.30hour and that anaesthetists remained on the Rochdale site until the patients left the theatre environment.

Nursing staffing

- Senior staff told us staffing of the day surgical unit followed 'British Association of Day Surgery' guidance and NICE guidelines SG1.No staffing red flag events had taken place within the day surgery unit. Staffing escalation guidance was in place for staff to access to ensure that safe staffing levels were maintained. We spoke with three staff who confirmed satisfaction with current staffing arrangements, which included staffing levels and skill mix.
- Each area had an identified funded staffing establishment. The day surgery ward was funded with 16.76 wte staff; in post, the unit had 16.15 wte staff. These figures included trained and untrained staff groups. One senior staff member identified that for the

last four years they had not held the full information relating to their budget. The budget and information relating to this budget was held by the band 8a senior nurse.
- Senior staff said theatres were funded for 71.81 wte staff of which there were 66.52 in post. Two band five staff were due to start, which would increase the actual staff in post to 68.52 wte staff.
- We were told that staff working in the unit had worked there for many years and there was very little sickness. Sickness data provided by the trust for the 8 months to 31st December 2015 confirmed sickness levels of 0.87% medical and dental and 5.04% for nursing and midwifery staff within surgery.
- One staff member identified difficulties deciding staffing requirements had occurred on occasion when a new theatre list was identified. This was because information about the complexity of the list was not provided which meant that staffing requirements could not always be fully identified.
- Staff confirmed that the unit opened from Monday to Friday, during this time a supernummary nurse at band six or seven coordinated the operation of the day surgical unit. We reviewed the staffing duty rota for week commencing 15 February 2016, which confirmed the presence of a senior nurse coordinator on shifts.
- The chief nurse had submitted to a trust nurse acuity staffing review paper (November 2015) to the trust Board in December 2015 which identified actions requested, corporate priorities, risks, development and assurance and resource implications. The review noted that operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations) and that this was currently under review.
- Staff on the day ward told us that an acuity tool was not used to determine staffing needs and the potential risk was mitigated by reviewing patient acuity and staffing at shift handovers. The 07.30 nursing handover included a 'nursing safety huddle', which included allocation of staff to patient caseloads and the discussion of patient related concerns or issues.
- Staff said agency nursing staff were rarely used. This comment was corroborated by a senior manager who confirmed that one bank healthcare support worker had been employed in the last 12 months. When agency or bank nursing staff were used, they were given an induction to the ward area, which included familiarisation with emergency procedures.
- Staff from the eye unit told us that bank and agency staff were not used at all as all nursing shifts were covered by permanent staff.
- Senior staff said staff sickness was rare and when it did happen, the shifts would be covered either by existing staff or through the nurse bank.

Surgical staffing

- The day surgery unit and theatres we inspected had a sufficient number of medical staff with appropriate skill's to ensure that patients received safe care. Medical staff told us that staffing levels in theatre were satisfactory.
- The Health and Social Care Information Centres (HSCIC) statistical data from September 2004 to September 2014 showed that the proportion of consultants was 39% compared to the England average of 41%; middle career doctors were 19% compared to the England average of 11%. The registrar group was 27% compared to an England average of 37%, whilst the proportion of junior doctors at the trust was 15% compared to an England average of 12%.
- Should patients remain in hospital their on call speciality team would provide the support and treatment for these patients. Patients requiring overnight stay from day surgery were either transferred to the acute medical ward if they had minor post-operative issues identified or to North Manchester General Hospital or Oldham Hospital if they were considered to have major issues. The operating surgeon was informed of unplanned admissions.

Major incident awareness and training

- The trust had a 'Service Continuity Policy and Strategy' to ensure critical services are delivered in exceptional circumstances. (v2.3, reviewed January 2016).
- The major incident plan for Rochdale urgent care centre (version 4.1, 12 November 2015) was supported by action cards for each clinical area. This plan identified staff specific roles and the measures to be put into place should a major incident take place. The 'Gold Control Team' was based at the trust headquarters (THQ) and includes the Chief Executive, Director of Nursing and

Medical Director. The gold control team controls the rest of the trust response to the major incident and liaise with external 'Strategic Control Gold' (SCG). A silver control team will be established on the affected site/s.

Are surgery services effective?

Good

We judged the effectiveness of the surgical service as good.

- The service provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had taken place.
- Care was provided in line with NICE CG50.
- Patient's surgical outcomes were monitored and reviewed through formal national and local audit. Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for people.
- Patients received care and treatment by trained, competent staff who worked effectively within the multi-disciplinary team.
- Consent was obtained from patients prior to procedures.

However we also found:

- That not all staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- The 'Core Standards for Pain Management, Faculty of Pain Medicine' were reviewed for compliance by the trust on the 18 February 2016. Information provided by the trust did not identify the action plan or monitoring arrangements in place in response to the shortfalls identified.
- Senior staff told us that a new governance structure was recently implemented trust wide. This meant that learning and monitoring processes from audits were not as robust as they should have been.
- The trust were unable to confirm whether Rochdale Infirmary surgical services met the NHS England seven day services priority standards around 'Time to first Consultant review.'

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed ten evidenced based / best practice guidelines. The guidelines were evidenced based and in date, for example the Prevention of VTE (venothromboembolism) Policy (V3) was based on NICE clinical guidance 92.
- Discussions with the surgical governance team and head of patient safety confirmed the surgical division had three out of date policies. Following the inspection further information was received from the trust which confirmed the number of out of date policies as nine. The trust had taken action to ensure these policies were either reviewed, updated or discussed at the next patient safety committee meeting. The latest policy status report, 'Document Management Status Report - Divisional Summary for Anaesthesia & Surgery' (25 February 2016) identified some movement in the status of individual documents since the existence of the new division. At the end of June 2015, nearly one in five (18%) of the division's live policies and guidelines had reached or exceeded their expiry date. A steady improvement was seen and at the time of this report, this figure had reduced to one in seven (13%) being at or passed their expiry date. The actions identified the division would continue to prioritise documents for review to ensure they were fit for purpose; stock checks' were underway to identify documents no longer required and those that could be merged together as part of their review.
- Local policies, such as falls prevention policies and risk assessments were written in line with national guidelines. Nursing staff told us that policies and procedures reflected national guidance and could be accessed on the trust intranet site.
- Evidence-based standards that build on the World Health Organisation Surgical Safety Checklist approach had been developed and tested by clinical experts. The standards, named 'National Safety Standards for Invasive Procedures (NatSSIPs)' were formally endorsed by a number of organisations. Senior staff told us the guidance for invasive procedures and standards was at implementation stage. Since September 2015, two multi-disciplinary meetings had taken place, which involved the medical governance lead, an anaesthetist and urologist. A project plan was formulated and activated in November 2015 to implement the NatSSIPs within the trust.
- Pre-operative investigations and assessments were carried out in accordance with NICE clinical guidelines.

- Care was provided in line with NICE CG50. This guideline identified measures staff take to recognise and respond to deterioration in the adult patient's condition. We saw that staff monitored the patient's progress throughout the patient journey from the pre-assessment stage through to the post-operative stage. Baseline physiological observations such as respiratory rate, heart rate and temperature were taken during the pre-assessment process followed by agreed frequencies of physiological observations at the patient's admission through to their discharge home. We observed that all patients were monitored in recovery and on the ward areas. Staff recorded parameters in line with CG50 and escalated to the anaesthetic medical staff as necessary.
- Senior staff told us that a new governance structure was recently implemented trust wide. This meant that learning and monitoring processes from audits were not as robust as they should have been.
- Reviews of surgical clinical audits and surgical policies, procedures and guidelines took place through the 'Surgical Governance & Quality Committee' in the Surgical Division and Anaesthetic Directorate.
- Senior staff told us that a new clinical audit strategy had just been approved and surgical specialities completed their own audit programmes.
- The trust World Health Organisation (WHO) compliance audit data from January 2015 to December 2015 identified Rochdale Infirmary's compliance in relation to completion of the WHO checklist. Compliance in WHO checklist (surgical safety checklist) completion was from 97% to 100%. The average score for sessions with a WHO briefing was 98%.

Pain relief

- Pain management is managed by designated anaesthetist staff in the day surgery unit. Initial requests for out of hours management are received by the anaesthetist on call for emergencies. This individual may or may not have intermediate pain training. The consultant on call for emergency anaesthesia provides expert advice when needed.
- The adult pain management team is led by two anaesthetists and a lead nurse who are contactable by bleep for advice on pain management issues. The pain team said no pain link nurses were based at the day surgery unit at Rochdale Infirmary.
- The pain team said a pain service information folder, which was updated monthly was available at each hospital site. Staff told us that the pain folder was available should they require written guidance in pain management.
- The 'Core Standards for Pain Management, Faculty of Pain Medicine' were reviewed for compliance by the trust on the 18 February 2016. The outcome showed that pain management services were not fully compliant against the core standards. In areas of none or partial compliance actions were identified to mitigate these shortfalls, for example, work was in progress to arrange multidisciplinary team meetings. Information provided by the trust did not identify the action plan or monitoring arrangements in place in response to the shortfalls.
- We tracked two patient's pathways who were admitted for day surgery; part of the pathway related to pain management. We observed pain management discussions took place with the patients prior to and post-surgery. We saw that a pre-operative assessment for post-operative pain relief had taken place and was documented. One of the patients we spoke with told us that they had experienced no pain following their procedure and that they had been given sufficient pain medication to ensure they remained pain free. Pain assessment tools were completed in those patient records we reviewed.
- We saw pain advice and medication advice given to a patient prior to discharge on the ophthalmic ward.
- Staff said that identified pain tools were not used to determine patents pain levels. For people with learning disabilities or dementia staff said they would observe non-verbal sighs to determine levels of pain. Discussions with the trust pain team identified that a new pain tool for patients with cognitive impairment was being rolled out across the trust.

Nutrition and hydration

- A variety of food choices was available to patients. Special diets, for example diabetic, gluten free, renal, textured and allergy diets were available.
- A selection of basic foods were available on the day surgical unit, which could be provided outside of the main meal times.
- Mothers breast-feeding their baby could access areas in which to breast feed their baby.

- A café and shop are located at Rochdale Infirmary, which could be accessed, by patients, carers and staff.
- One patient told us that following their procedure they had been given something to eat and drink prior to being discharged home.
- We were told that staff approached the dietician who was based at Oldham Hospital for advice regarding patient dietetic queries as there was no designated dietician on the Rochdale Infirmary site.
- Nutritional evidenced based / best practice based guidelines were available for staff to access. We reviewed five guidelines and noted they were all in date.

Patient outcomes

- The trusts hospital episode statistic (HES) for July 2014 to June 2015 showed that 13,200 patients were admitted for surgery at Rochdale Infirmary.
- The trust target for theatre utilisation was 85%. No theatres at Rochdale Infirmary were used at more than 88% utilisation from August to October 2015 (Pennine Acute Hospitals NHS Trust pre-inspection document, January 2016)
- HES data from June 2014 to May 2015 identified that the relative risk of readmission for elective admissions for Rochdale Infirmary were generally below the England average. The top three specialities based on the number of readmissions were ophthalmology, colorectal surgery and general surgery. A value below 100 was interpreted as a positive finding. The general surgery ratio was 102 compared to an England average of 100.
- Staff told us that post-operative telephone calls for patients who had undergone anti-reflux surgery were made as part of a pilot. The telephone calls were made by nursing staff to post-operative patients to follow up on the patient's progress and to monitor for early post-operative outcomes such as nausea, vomiting and pain.
- Patient-led assessments of the care environment' (PLACE) assessments provide a snapshot of how an organisation was performing against a range of non-clinical activities which impact on the patient experience of care. These include, cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance of healthcare premises and dementia (whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria). The PLACE assessment at Rochdale Infirmary took place on the 6 May 2015. The outcome of this assessment showed that the trust was rated higher than the national average on cleanliness, privacy, dignity & wellbeing, condition, appearance and maintenance and dementia friendly environment. However food & hydration scored lower (88%) than the national average of 88.49% which was a fall of 1.01% compared to 2014. Separate figures for Rochdale Infirmary were not available. Following this assessment actions and recommendations were identified. One action, which related to Rochdale infirmary included a review of outdoor signage. This had been undertaken and quotes obtained to update signage.
- We reviewed information pertaining to a retrospective re-audit of ophthalmic theatre cancellations at Rochdale Infirmary from 1 November 2013 to 30 June 2014. The summary of observations identified that the number of cases cancelled in the re-audit showed a reduction of 30%. Areas, showing improvement, included the documentation of reasons for cancelled operations or procedures. Three areas were identified for improvements and four recommendations identified. The audit action plan dated 30 June 2015 confirmed the date for implementation and review date against the four recommendations as 31 December 2015. We noted that the college guidelines recommendation was discussed and was noted on the action plan. The other three areas for action progress updates were not given.
- We requested information which related to Rochdale Infirmary's participation in the Anaesthesia Clinical Services Accreditation Scheme (ACSA), including accreditation level, to-date, this information had not been provided by the trust.

Competent staff

- Staff told us that all new nurses were supported to complete a diploma with Manchester Eye Infirmary to deal with emergency eye care. This course comprised of two 17-week modules, which included a final assessment.
- Staff told us that staff could approach link trainers for advice and support in areas such as pregnancy testing, tissue viability, diabetes and resuscitation.
- Staff had taken on extended roles, for example, male catheterisation.
- Staff yearly appraisals were reviewed at six months. Appraisal data provided by the trust for Rochdale Infirmary in 2014 -2015 confirmed completed appraisals

as 89% for nursing staff from the eye ward, 100% of day surgery staff and 96% theatre nursing staff. The April 2015 - November 2015 appraisal data confirmed between 71% to 93% compliance for these three areas until November 2015. Staff told us that the appraisal process was useful as this process encouraged them to identify their training needs for the next year.

- The 'Medical Revalidation & Appraisal Quarterly Report' for November 2015 confirmed the appraisal cycle for 2015/16 ended on 28th February 2016. Appraisal statistics for medical and dental staff for April 2014 to March 2015 confirmed that 100% of consultants had an appraisal. For the year April 2014 - March 2015 figures provided confirmed that 40% of medical and dental staff had an appraisal.
- The ward manager completed a 'Day Surgery Certificate 'previously, whilst another nurse was completing a counselling course as a top up to their nursing degree. One staff member told us they had protected teaching days where they had completed live scenario training in conflict resolution.
- Senior staff confirmed that staff had completed training programmes in areas such as anaesthetics, recovery practitioner and scrubs practitioner during their first six months working on the unit or in theatres. We saw one nurse's completed scrub practitioner documentation from 2009. We asked to see further evidence of staff training, however this information was not present in the three staff personnel files we were shown.
- The trust identified there was no specific critical care training in place for recovery staff. Instead, staff completed in-house training competencies and could access modules for recovery and advanced recovery at a local university.
- The trust identified 28 staff worked within the theatre recovery areas at Rochdale Infirmary. All 28 staff had completed training in the anaesthetic/recovery module; Anaesthetic Nursing (ENB 182). Recovery staff also undertook training in intravenous drug administration, extubation and 12 lead electrocardiograms (ECG).
- Mental health awareness training had recently been introduced for staff and a further training session was planned for March 2016. The training sessions, which had taken place at Rochdale Infirmary, did not identify the attendance rate of nursing staff from the surgical service at Rochdale Infirmary. Surgical training statistics for 2015 – 2016 identified 19% of nursing and midwifery staff and 4% of medical and dental staff had accessed mental health awareness training sessions.
- All middle grade and junior doctors had allocated clinical and educational supervisors. In relation to general trainee supervision to develop skills, 100% of junior and middle grades had supervision from a consultant. Consultants did not have routine supervision.
- Staff told us that formalised clinical supervision was not available, however, an open door policy existed to discuss things as part of their clinical supervision. A six-month preceptorship package was in place for new starters.

Multidisciplinary working

- Staff from the eye centre told us they were involved in multi-disciplinary team (MDT) meetings.
- Staff told us that daily 'safety huddle' MDT meetings took place where issues such as incidents and safeguarding issues were discussed.
- Doctors and nursing staff told us they worked well together within surgical specialities. We saw evidence of this in the theatres and day surgery unit in that there was good communication seen between healthcare professionals.
- Staff said that effective team working existed between themselves and other hospital departments so that patients care needs were met.

Seven-day services

- Staff confirmed effective multi-disciplinary team (MDT) working in the unit and externally to provide seven-day services. Doctors, pharmacy support and radiographers were easily accessed out of hours.
- Patient investigation results could be accessed easily, for example, the online patient x-ray (PACs) system provided staff with details of the patients x-rays pre-operatively.
- Staff told us that staffing levels were sufficiently maintained up until the unit closed at 8pm Monday to Friday. Following the units closure existing patients not fit for discharge were transferred to an inpatient ward at Rochdale Infirmary or to an inpatient ward at another hospital site within the trust.

- We asked the trust whether Rochdale Infirmary surgical services met the 'NHS England seven day services priority standards around 'Time to first Consultant review and were told that the division was still in discussion.

Access to information

- Staff gave examples of how information had been shared amongst the multi-discipliniary team. For example, where a patient had required a pain injection following discharge the nursing staff had contacted the pain team to ensure that the referral for the pain injection was put in place and the pain team knew which patient required their support.
- District nursing staff received a patient's initial referral via secure fax. For those patients who required removal of their sutures the nursing staff liaised with community nursing staff.
- The patients GP received information about their procedure / treatment via a written paper record, which the patient gave them. GPs also accessed patient information through the patient's online healthcare record.
- Patient's occupational health and physiotherapy referrals were initiated by the patient's doctor who then arranged for the referral to be sent to the relevant allied healthcare professional.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff identified different consent forms were used to obtain patient consent. The consent forms used were dependent on the following factors: the type of procedure, the patient's ability to consent, for example, patients with dementia type conditions or learning disabilities and for patients whose consciousness was not impaired.
- Discussions with one post-operative patient confirmed they had been informed of what to expect following surgery and during the preoperative period had signed a consent form.
- We saw that consent forms had been completed and signed in five patient records.
- We asked six staff what their understanding was in relation to the Mental Capacity Act and Deprivation of Liberty. Four staff described what these areas involved. The other two staff were not able to confirm an understanding of these areas.

Are surgery services caring?

Good

We judged caring as good as the service provided caring services to the local population.

- Patients received compassionate care with good emotional support.
- Patients were fully informed and involved in decisions relating to their treatment and care.
- Support was provided by the multi-disciplinary team during the patient's admission, stay and in preparation for their discharge home.
- Patient's emotional needs were supported throughout their surgical experience.

Compassionate care

- We spoke with six patients and one family member who told us they had generally been happy with the care and support they had received. One patient said, 'Fantastic", "Can't fault them", "Nothing but praise", "Spotless. '
- We saw that staff treated patients and relatives with dignity and respect.
- Throughout the inspection, we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of patients. Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- Staff told us an action plan was produced following the 2014 inpatient survey. One example of a change made following the patient survey feedback had been to improve the day surgery information booklet.
- 'HAVE YOUR SAY… Your time in hospital' leaflets were available in pictorial and written form for people with learning disabilities to provide feedback following their hospital experience.
- Feedback cards and comment boxes were available to use throughout the service.
- The friends and family test (FFT) asked patients at discharge whether they would want their friends or family to be treated at their hospital.

Understanding and involvement of patients and those close to them

Surgery

- We observed a patient discharge and saw that everything was explained clearly and advice given should the patient experience problems. Information was also provided of whom the patient should contact out of hours if they had any problems.
- Patients told us that they had discussions pre-operatively about their procedure during the pre-admission clinic. Post operatively information was provided by the nursing and medical staff about their procedure and what to expect.
- In the anaesthetic room and all procedures were fully explained to the patient. Staff checked for the patients understanding of the procedures.
- Staff called relatives to ask them to collect the patient explaining the processes to ensure a safe discharge home.

Emotional support

- In theatres, we observed that theatre staff welcomed patients into the anaesthetic room, put the patient at ease and answered any the patient's questions.
- In theatre, staff were respectful towards the patient when the operation was in progress.
- Staff showed compassion when talking to patients in the recovery ward when they were not fully conscious.
- Staff showed a good awareness of patients with complex needs and / or those people with a learning disability. Staff told us during the initial pre- assessment staff determined what immediate support the patient required. Patients were given the option of visiting the day surgery unit prior to their surgery / procedure to familiarise them with the environment and meet the staff therefore reducing the patient's anxiety levels.

Are surgery services responsive?

Good

We judged responsive as good as the service provided responsive services to the local population.

- The surgical service had good support from the surgical centres within the trust and from tertiary centres.
- Service planning and delivery considered the patients' needs, which meant changes to the service and how it was delivered, benefited the patient.
- There was good access and flow to services, which met patient's needs. Service developments had improved patient access to treatment by the introduction of new elective lists.
- The 18-week referral to treatment (RTT) – pathways performance data confirmed the trust had achieved 95 – 96% compliance against the RTT standard of 92%.
- The RTT standard had been achieved for all specialities and had the 8th best national risk assessment score.
- Learning and changes to practice had resulted from complaints.

Service planning and delivery to meet the needs of local people

- Staff told us that outpatient cystoscopy clinics had been developed two years previously.
- A lithotripsy nurse led clinic commenced in April 2015. Lithotripsy is a procedure that uses shock waves to break up stones in the kidney, bladder, or ureter (tube that carries urine from your kidneys to your bladder). After the procedure, the tiny pieces of stones pass out of your body in your urine. The lithotripsy service moved from Fairfield General Hospital to Rochdale Infirmary where less invasive equipment had been provided. This service proved such a success that additional sessions are now provided. The service will be audited in March 2016 at which point an audit programme will be implemented to monitor continued improvements.
- The Rochdale Infirmary day surgery unit and associated discharge services are nurse led.
- To ensure the changing needs of local people are met, 'Healthier Together' has been looking at how patients will receive health and care in the future. The Healthier Together programme is a key part of the wider programme for health and social care reform across Greater Manchester and comprised of three parts: Primary Care (including GP services, Joined up Care and Hospital Care.
- The programme was clinically led by health and social care professionals and its aim is to provide the best health and care for the people of Greater Manchester. Under 'Healthier Together.' The hospital plans to drive up quality and safety, 'single services' will be formed and there will be networks of linked hospitals working in partnership. This means care will be provided by a team of medical staff who will work together across a number of hospital sites within the single service.

Surgery

Access and flow

- The trust agreed the 'Operational Policy, Elective Access - Booking and Scheduling Department' (version 1) with local Clinical Commissioning Groups (CCGs) so that guidance was in place for the elective access booking and scheduling (B&S) team to manage patients waiting for treatment on an elective pathway. It relates to patients requiring access to elective outpatient treatment, elective inpatient treatment and diagnostic tests.
- Day case surgical admissions were based on elective surgical pathways, which started at pre-admission clinics based at other hospital sites following the patient's referral for treatment. On the day of treatment the patient would attend Rochdale Infirmary and their surgical pathway would continue initially in the nurse led peri-operative area. From here the patient would be taken to theatres and following their procedure into theatre recovery then onto a designated male or female ward area to fully recover.
- The referral to treatment data (RTT) target is 92%. Staff said that RTT was managed by speciality, not by site, which meant that RTT information provided by the trust related to all sites the specialities were based on. Following the inspection we spoke with a senior staff member who provided additional information which confirmed that the 18-week referral to treatment (RTT) – pathways performance data confirmed 95 – 96% compliance against the RTT standard.
- The December 2015 trust 'Integrated Performance Report (IPR) confirmed that the RTT standard had been achieved for all specialities and had the 8th best national risk assessment score.
- The average length of stay at Rochdale Infirmary (RI) for the top three specialities identified by hospital episode statistics (HES) data (July 2014 – June 2015) showed that the average length of stay for elective ophthalmology, colorectal surgery and trauma and orthopaedics was lower or the same as the England average.
- In 2015 day case hip arthroscopy services commenced on average two to three times a week to improve patient waiting lists in this area . Patient suitability for these procedures are determined by the surgeon.
- Staff told us that urgent elective and emergency patients such as those undergoing minor orthopaedic work were taken from Oldham Hospital to facilitate patient care and fill lists. Staff told us they were happy assisting with these lists if it meant lists were utilised more. The frequency of these lists were described by staff as low.
- Staff told us that patients' needs were evaluated prior to discharge home and the necessary support provided. For example if they needed walking aids, these were provided prior to discharge. We observed the discharge information given to one patient and during this episode; the staff member gave clear explanations to the patient of what to expect post operatively in relation to their wound. A wound care leaflet was given to supplement the verbal information. The consultant's instructions, preoperative conversations, medication needs and the pending outpatient appointment were also discussed.
- Patients post discharge information included advice on who to contact should they experience post-operative problems. The advice included either contacting the out of hours GP service, attending the emergency department at North Manchester General Hospital or Oldham Hospital or the minor injuries unit at Rochdale. The eye unit provided an emergency eye service up to 8pm.

Meeting people's individual needs

- Single sex accommodation was provided throughout the day surgery unit. For example, male and female patients waited in designated single sex waiting rooms and following surgery were nursed in designated male and female ward areas.
- The Ethnic Health Department provides verbal and written language interpretation services for over 82 languages spoken within the geographical area of the Trust.
- The British Sign Language Interpreting services were provided for patients with sensory difficulties, braille or large text documents were provided for visually impaired patients.
- Telephone interpretation service was provided for non-urgent standard consultations or appointments.
- A Translation service was provided upon request.
- The learning disability service, which was part of the safeguarding team, works in liaison with learning disability liaison nurses to ensure patients with a learning disability are supported when they visit hospitals within the trust. Advice and training to hospital staff has been provided through this service so that staff

are enabled to provide the most appropriate care for patients with a learning disability. They also worked with staff to ensure that reasonable adjustments can be made for each patient either coming into or who already is in hospital.
- Patients with learning disabilities completed a 'Traffic Light Assessment' tool, which identified information about their specific needs.
- Relatives and carers were also involved and 'walk through the patient journey' with the patient prior to their admission so that they understood the process and can help the patient undertake this journey.
- Information was available to patients and carers to help them when they attend hospital as either an in-patient or outpatient. For example, 'Patients with a learning disability: Care within hospital - An information guide' (February 2015). We observed that this guide's review date was February 2015. The guide included a nursing and carer agreement in relation to the patients care requirements and who would be accountable for assisting them in these areas. A pictorial version of this document was also available for patients (date of next review March 2017).
- The trust had implemented a dementia strategy in October 2015 and had appointed a dementia lead, to enhance the life and quality of care for people living with dementia. We saw training statistics, which confirmed that staff, had completed level one dementia training at Rochdale Infirmary.
- Staff told us that patients with dementia type conditions would complete the 'This is me' document, with the help of family and bring this information into hospital with them.
- Guide dogs accompanied their owners. Disabled parking is located near to main entrances on each hospital site.
- We observed an operating department assistant assess a patient to ascertain their particular needs. For example, a footrest was required to raise the limb for the surgeon to operate.

Learning from complaints and concerns

- Patients could access information about how to complain and direct their concerns and complaints either to the hospital complaints department or through the patient advice liaison service. For those patients with a learning disability information in an easy read pictorial format could be provided on 'How to Make a Complaint.' We saw that this information could be accessed in a number of languages and information, which advised this, was present.
- Staff said that patients were invited to discuss their complaint and were involved in determining the lessons learnt from such complaints and / or incidents.
- We reviewed the complaints log for the eye centre. Action plans were in place and lessons learnt identified.
- Complaints, which relate to the day surgery unit were managed by the unit manager.
- The trusts 'Complaints Handling Policy (v7, ratified 26 November 2015)' included actions, which staff must take in line with the Duty of Candour (being open).

Are surgery services well-led?

Good

Overall, we rated the leadership of surgical services at Rochdale Infirmary to be good.

- A trust wide transformational programme was in place and trust core values identified.
- Governance, risk and quality measurement processes were in place. A service risk register was in place, which identified areas of risk.
- A safety programme had been implemented and safety issues were regular topics for discussion through various forums and media.
- The trust had introduced nursing metrics to measure performance in identified clinical areas in February 2016.
- A clear leadership structure was in place within the service. Individual management of the different areas within the day surgery unit were well led.
- Generally staff felt supported within their teams and were given opportunities to develop their management skills further.
- Staff described a positive team working culture.
- Public and staff engagement processes captured feedback from both groups, which was generally positive.
- Innovative practice included the introduction of the smartphone app called 'SmartGP (Pennine Acute)',

aimed at GPs and users in primary care to assist in identifying services provided by The Pennine Acute Hospitals NHS Trust and to provide contact information to access those services.

However, we also found:

- The governance framework and associated governance leads were new within surgery. This meant governance processes would need time to develop and embed.
- Formalised surgical service strategies were not in place, however, we were told that the surgical service was developing plans in line with 'Healthier Together.'
- Some staff we spoke with identified limited knowledge of the trust core values.

Vision and strategy for this service

- In 2015, the trust captured staff feedback through 'Pride in Pennine' online workshop processes. The trust identified that staff shared nearly 27,000 ideas, comments and votes to co-create our Trust vision, values and goals. The trust values, which were jointly agreed, were Quality-driven, Responsible and Compassionate. We asked five staff what involvement they had in developing the core values and were told by three staff that they had not been involved in their development. Two staff said they did not know what the core values were, whilst, two other staff thought the values centred on treating patients with 'dignity and respect.'
- The surgical service does not have a formalised strategy in place; however, we were told that the surgical service was developing plans in line with 'Healthier Together.'
- The trust had developed an overarching transformational map (2015 / 2016) which identified 'Quality as our first priority.' Two staff we spoke with were aware of this vision and plan. The trust identified ten corporate priorities for 2015 – 2016, which include driving up quality and performance and progression toward foundation trust status.

Governance, risk management and quality measurement

- The chief executive officer confirmed that from May 2015 new directorate triumvirate structures had been put in place, which included new clinical directors and clinical governance divisional support. We met with the new surgical clinical governance team who confirmed that since this staff reorganisation they had been redefining the surgical directorate's governance system to enable it to be fit for purpose for the current service. A new risk manager started two weeks before our inspection and a service risk improvement plan is now in place. The service risk register identified risks across the service.
- Following a review of the governance system and membership, the governance framework was now led by a governance lead and the medical director. Initially there was limited consultant involvement due to consultant vacancies and consultants not becoming involved in the governance system. Governance involvement was reflected within the job plans of consultant staff. In December 2015 an internal audit, which also had input from an external observer took place to ascertain the effectiveness of governance meetings. Following this audit there was increased engagement from clinical staff and action plans result from these meetings.
- In February 2015, nursing metrics were rolled out. The metrics included measurements on pain, pressure ulcers, falls with harms and new venous thrombus embolisms. Pressure ulcers remain one of the divisions major care problems throughout the service. In response, the surgical division was working closely with the tissue viability and corporate nursing team to reduce pressure ulcer incidence.
- Senior staff told us that a new clinical audit strategy had just been approved.
- A safety programme had been implemented by the patient safety team to focus on incidents and complaints.
- Safety issues were highlighted to staff groups through weekly 'Spotlight on Safety' newsletters from the chief executive officer and the quarterly 'Pride in Safety' newsletters. The winter 'Pride in Safety' newsletter identified that its aim was to share learning across the organisation. One topic included the role of the safety improvement programme whose aim was to improve safety in eight areas, one of which was safer surgery.
- Quarterly 'Learning from experience' reports fed into divisional meetings.
- Staff from the eye centre told us they were involved in departmental audit meetings, which reviewed current practice.
- Weekly theatre resource meetings took place to discuss patient gaps, late starts and early finishes in relation to theatre lists. The anaesthetics manager, booking and scheduling person's and designated theatre staff were

present. We saw the minutes of the theatre resource meeting dated 9th February 2016 for theatre utilisation for weeks commencing 1 February 2016 on the Rochdale Infirmary site. The minutes confirmed there had been 11 cancelled sessions and four reallocated sessions, which meant seven theatre sessions were cancelled that week. Information about high risk patients and the reason's contributing to this risk status was also documented.

- A weekly ward safety huddle document was completed by the nurse in charge. Information provided on this document included, the top five risks, top five categories of incidents, serious untoward incidents for the previous week, training compliance, friends and family test and compliments and complaints data. The completed January 2016 weekly ward huddle for the day care unit and theatres was requested but was not provided by the trust. The trust provided the minutes of the Rochdale Infirmary theatres team meeting dated 15 February 2016 instead. We saw subjects included infection control, complaints feedback and the new dementia strategy.
- We saw discussions relating to speciality audits, mortality and morbidity had taken place, for example this was demonstrated in the minutes from the trust wide 'Upper GI/Colorectal Surgery Governance/Clinical Audit Meeting (23 September 2015).'

Leadership of service

- A leadership structure was in place, which comprised of a lead divisional director, divisional medical director and divisional nurse director. A directorate triumvirate, service managers and clinical management teams were identified within the operational model, which reported into the director of operations.
- The day surgery unit senior nursing team included nursing management a band 8a unit manager and three band seven sister roles. The theatre manager reported to a senior nurse manager.
- We received some mixed feedback from senior staff in respect of the support they received from their immediate manager. One manager raised concerns about that sharing of information and ongoing involvement in decision making in relation to the operation of the unit and patients' needs did not always take place.
- Staff said that all band 7 staff met with the band 8a theatre manager through a number of forums. These included two weekly meetings with the theatre manager, band seven meetings where all three band seven staff attended and theatre departmental meetings.
- One member of staff said they knew the executive team by sight, although, had never met them or spoken with the chief executive officer (CEO). Another staff member said that the chairperson had visited the day surgery unit two years ago.
- One staff member said that they should have attended management training days, however, had been unable to do so as the information relating to these training days had not been provided despite asking. Another staff member had attended human resource training and completed management training prior to taking on their existing role.

Culture within the service

- Staff were very positive about their experiences of working within the day surgery service at Rochdale Infirmary. They told us that they provided an efficient service, that staff at all levels were approachable and friendly and it was a good place to work.
- Staff told us of a good team working culture where staff helped each other.
- The trust identified that there had been no formal training on 'duty of candour', although it is covered in a training video, which can be accessed by staff. The trust identified that statistics, which identified the total number of staff who had watched the training video, were not collected. The head of patient safety confirmed that a 'duty of candour' policy was in place and recently a staff guide for 'duty of candour' had been launched and disseminated across the Trust to staff groups. The trust identified that some staff had attended this training in January 2016 but did not confirm whether any of these staff included staff from Rochdale Infirmary surgical day unit or theatres.
- We saw that the trust's 'Pride in Safety' winter newsletter identified guidance for staff on what they should do in relation to 'Duty of Candour – Being Open With our Patients and their Families.'

Public and staff engagement

- Staff said that the CEO sent staff weekly Monday messages by email. We saw the Monday message dated 22 February 2016, which contained a range of

information, for example, the new patient advice liaison service was now located 'front of house.' Additional information included the Care Quality Commission visit and a spot light on safety section.
- Staff receive monthly editions of 'Team Talk' which is a magazine produced by the executive team to inform staff of the latest news.
- Staff confirmed that monthly team meetings took place and that they could add areas for discussion to the agenda prior to the meeting.
- Staff said they had received good support and regular communications from their line manager on the day surgery ward.
- Theatre staff told us that discussions in unit meetings included incident feedback and learning and highlighting those policies and procedures, which the incidents may relate to, for example, needle stick injuries.
- The NHS Staff Survey 2015 identified that 57% (average for acute trusts is 70%) of staff would recommend the trust to family and friends if they required care or treatment and
- A score of 49% (average for acute trusts is 61%) by staff identified they would recommend the Trust as a good place to work. These figures showed an increase of between one to three per cent from the 2014 staff survey.
- In response to the NHS Staff Survey findings and Picker Institute's report into the staff survey the findings were discussed by members of the senior management team (SMT) in February 2016. The SMT were asked to support the development of further actions to drive an improvement over the next six months before the start of the 2016 survey in September 2016.
- Staff identified that patients were invited to the trust annual general meeting, involved in PLACE visits and were invited to a series of 'Listening Into Action' focus groups throughout the year.

Innovation, improvement and sustainability

- The trust had introduced nursing metrics to measure performance in identified clinical areas in February 2016.

The trust had launched a smartphone app called 'SmartGP (Pennine Acute)', aimed at GPs and users in primary care to assist in identifying services provided by The Pennine Acute Hospitals NHS Trust and provided contact information to access those services. Navigation in the app was easy, intuitive and there were a number of useful tools such as a training log, reminder utility and an expenses log. There was also a 'Feedback' area to report incorrect numbers or to provide suggestions on how the software could be improved. GPs using their smartphone would be able to access information on the trust from wherever they have an active cellular or Wi-Fi signal. It's been recognised as a useful reference when reviewing a patient's care, whether in the surgery or at the patient's home.

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

Rochdale Infirmary was the smallest of the four trust hospital sites. It was a new hospital with four floors. The out-patient department (OPD) was on the third floor and each of the six OPD suites had its own waiting area. A number of clinics were provided on site including orthopaedics, urology, and rheumatology, pain, respiratory and infectious diseases.

Radiology was on the ground floor; there were two digital radiography X ray rooms with new equipment; computed tomography (CT) and magnetic resonance (MR) imaging There were no pathology services on the Rochdale site.

The population attending the hospital have a lower life expectancy than the England average and 46% of the population of North Rochdale live in the bottom 20% of the most deprived areas in England. The black, minority ethnic population is 20 %.

There were 142,970 outpatient appointments at Rochdale Infirmary from July 2014 to June 2015 and 701,767 for the trust overall.

We visited the hospital on the 25 February and we spoke with two radiographers, the senior sister in the OPD and a staff nurse. In the booking centre we spoke with the senior manager, who was the interim lead of elective access and the acting cancer services manager, the transformation lead and the head of department. We also spoke with three patients and two carers in the OPD.

During the visit we spoke with staff and patients. We reviewed a range of patient records and trust policies and documents. We also reviewed information and data from a number of sources before and after the inspection.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatient and radiology services at Rochdale as good overall. This was because

- Staff were using national guidelines which were being reviewed for compliance by the trust. There were good opportunities for staff development and there was evidence of good relationships between doctors and nurses and effective multi-disciplinary team working.
- Mandatory training levels were good and the environment was visibly clean and tidy. Equipment was checked regularly and there was evidence to support this. Staff knew how to report incidents and this was followed up through regular staff meetings.
- Leadership was effective in the OPD but not as good in the radiology department where there had been some recent changes in the management arrangements.
- The department had scored well in the family and friends test.
- There had been a number of missed cancer diagnoses at the trust and these had been reviewed and actions had been put into place to reduce this risk of this happening again.

However

- The trust did not have any mechanism to measure the length of time that patients waited to see a clinician.
- The did not attend (DNA) for appointment rates in OPD were higher than the England average and the trust did not have anything in place to address this. DNA rates were also high in the radiology department.
- There was a lack of clear management structure and reporting accountability following management changes in the radiology department

Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatients and diagnostic services at Rochdale infirmary as good in the safe domain. This was because

- Staff knew how to report incidents and feedback to staff at meetings was good. There had been a number of serious incidents at the trust which had been investigated and lessons were learned. There had been a number of incidents of missed cancer diagnoses which had been investigated by the trust following a look back exercise over five years. An improvement plan and action plan had been put in place to reduce the risk of this happening again.
- The outpatient areas were visibly clean and tidy with plentiful personal protective equipment available for staff and hand hygiene audits were completed. In the patient led assessment of the care environment the hospital scored above the national average for cleanliness.
- Mandatory training levels were good and the trust had a system to update managers on a weekly basis about the status of staff mandatory training. Resuscitation trolleys were checked daily and this was recorded. Nurse staffing was adequate though there were vacancies and a recruitment day was planned. There were vacancies in radiology and radiography and recruitment was underway.
- In the radiology department appropriate processes were in place to ensure that radiological requirements for the department were met.

However

- Medicines were kept in a locked cupboard in the matron's office and were put into trays when needed in clinics; this was recorded on the risk register as they should have been in locked cupboards in each clinic.

Incidents

- There have been no never events and no serious incidents at the hospital between November 2015 and January 2016; 18 incidents were recorded, these incidents were risk assessed as no harm incidents or low harm incidents.
- Staff knew how to report incidents and were encouraged to do so on the trust electronic system. At Rochdale the OPD staff would inform their manager before reporting the incident on the system. Most incidents were cancelled clinics and late running clinics. Staff meetings were used to feed back to staff about incidents.
- We heard staff apologising to patients if clinics were running late and we spoke to a patient who had been sent an appointment for the wrong day. Staff apologised to the patient and their relatives and ensured that patient was seen in a timely manner.
- There was separate incident reporting for radiology services. There was evidence of incidents reported to the radiation protection supervisor at Oldham and reports to the radiation protection for supervisors (RPS). Staff said that they didn't always get feedback about incidents.
- The trust was undertaking a piece of work to reduce the number of incidents as a result of missed diagnoses of cancer across the trust. There was a five year look back exercise and a total of 159 cases had been reviewed. Of these, 40 cases were identified as definitely preventable and in 13 cases there was strong evidence of preventability. There was an improvement plan that was overseen by the diagnostics improvement group and this was submitted to the quality and performance committee of the board. The learning from the review identified a number of key areas different parts of the patient pathway. There was a trust action plan which included a number of areas including patient engagement, reviews of processes and patient pathways and revised policies and procedures. A piece of work was underway called your request/your responsibility which was training to advise staff on the correct procedures for referring and reviewing radiological testing. The improvement plan was submitted to the quality and improvement committee on the 23 February 2016.
- In the next three months the trust were implementing the CRIS communicator which will enable referrers to radiology services to ensure that patients with critical findings would be seen more quickly and an audit trail of messages would be sent and there would be acknowledgment of receipts of reports for the provider.
- Letters were sent to all those affected by the issues, with an apology. There was information to raise awareness for patients about this matter in the radiology department but we didn't see any in the OPD.
- There had been specific training sessions for radiology staff about the duty of candour at governance and audit days.
- Incidents about radiation were dealt with by a nearby cancer specialist hospital that would check to see if patients had received too much radiation. The staff who administered the radiation would have a 1:1 with the radiation protection officer and would write a reflective piece about the incident.

Cleanliness, infection control and hygiene

- All areas we visited in the OPD were visibly clean and tidy. Curtains were disposable and the ones we checked were dated and within date. There were hand gel stations in the OPD which were well used and there were posters for patients about infection control.
- Facilities for hand washing were available at the entry point of each room in the OPD
- Personal protective equipment (PPE) was available in all the OPD clinics that we visited.
- There were hand hygiene audits in the OPD every two months. The target was 90% though 100% was usually achieved. There were also trolley mattress hygiene audits every three months.
- In the patient led assessment of the care environment (PLACE) the hospital scored 99.5%, the national average was 95.6% for cleanliness,
- Contaminated waste was stored and disposed of correctly, sharps bins were sealed and dated.
- The infectious disease clinical room was not used by other services.
- There were audits in radiology for hand washing, room cleanliness and equipment cleanliness. All areas were visibly clean and tidy.
- PPE was plentiful and available in the radiology areas that we visited.

Environment and equipment

Outpatients and diagnostic imaging

- The OPD at Rochdale was welcoming and clean and tidy. There was a café providing refreshments in the main reception area.
- Local rules about the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) were signed and displayed in the radiology department.
- The radiographer was unable to locate the key documents including radiation risk assessments. These should be accessible for all staff in each dept. They are devised by the Radiation Protection Advisor (RPA) and senior radiography staff and cover likely maximum daily exposures, groups of staff involved and numbers of patients imaged. They should be refreshed every three years and revised annually

Medicines

- Medicines at all the trust sites were stored in the matron's office in locked cupboards. Trays of medicines required for each clinic were put into trays for the use of the doctors or specialist nurses. These trays could be left unattended if the doctor left the clinic and if there was no nurse present although we did not see this during the inspection. This was the highest risk on the departmental risk register and the trust was working with pharmacy colleagues to provide locked cupboards in each clinic.
- Prescription pads were locked away until they were needed.
- Fridge temperatures were monitored daily and we saw that temperatures were in range.
- There were no controlled drugs used in OPD.

Records

- The trust used an electronic records system which had a clinical history sheet which ensured legibility; there was availability at all locations and the removal of risks round paper transportation and loss of records. The trust were also replacing the current elective admission proforma and using an intranet based referral that would allow the information to be saved into the electronic clinical record.
- Consultants liked the system although it could sometimes be slow and they could use their electronic hand held devices if the system was down. This allowed them access to the appropriate records. They also said that day cases could be a problem if the information was not scanned onto the system though they would have the referral letter.
- Data supplied by the trust showed 99.81% of patients were seen in the OPD with their medical records. If the notes were unavailable the paper notes were retrieved in advance of clinic and where these were absent this was escalated to the team leader. If the records remained unavailable a temporary set of notes was created and included relevant documents held in electronic format such as referral letters and diagnostic results and trust systems.

Safeguarding

- The OPD staff were aware of safe-guarding of adults and children. Trained staff received training to level three, untrained staff were trained to level two in the safe-guarding of children and reception staff were trained to level one. Staff knew how to report safe-guarding incidents and how to refer urgent issues to the safe-guarding team. Staff would flag up injuries that could have been caused by domestic violence in the trauma and orthopaedic clinic and refer these to the safe-guarding team.
- Prevent training was part of level two and level three safeguarding training; this was to prevent young people to be drawn into terrorism.
- The patient administration system (PAS) would flag up any safeguarding alerts.
- All the band six and above staff in radiology were trained to level three in the safeguarding of children and vulnerable adults.

Mandatory training

- Mandatory training levels for OPD staff across the trust were 93% but at Rochdale they were at 100%. The trust produced a weekly chart which informed managers of the status of the mandatory training of all the staff. This was updated every Monday and enabled managers to allocate training time for staff dependant on any short term sickness/absence. The online training required a short test for completion and staff said that the training was good.
- All the staff in OPD were trained in basic life support skills. This was done in house.
- Compliance with mandatory training was at 100% for the staff in the booking centre.

Assessing and responding to patient risk

- There were resuscitation trolleys in OPD and diagnostics for adults and children which were tamper proof. There

was a hypo box for patients with low blood sugars attending the OPD and the glucometer to measure the patient's blood sugar was calibrated daily. We saw that these were checked daily by two members of staff, a qualified member of staff and an unqualified member of staff, and that this was recorded. There was an audit trail so managers knew who was supposed to check the equipment every day.
- Oxygen was available in some of the treatment rooms including the colposcopy suite.
- The last menstrual period sheet was completed for all women of child bearing age in the radiology department. If there was any doubt a pregnancy test would be undertaken.

Nursing staffing

- The allocation of nurse staffing was decided each morning dependent on short term sickness and absence. There was always one trained member of staff for each of the seven OPD areas. Senior staff said that nurse staffing could sometimes be a problem but staff would help out at other sites if necessary. There was an escalation policy for the staffing of the department. Clinics were never cancelled due to nurse staffing.
- The consultants said that the OPD clinics were well staffed though it was sometimes difficult to staff evening and weekend clinics.
- A member of staff was rostered to remain in clinic until everyone had left and staff received time in lieu for this. They sent an email to their manager when they were leaving the hospital.
- Senior nurse manager said that it was difficult to get staff to do additional evening clinics and they usually cover the clinics themselves.
- There was a bank of staff for OPD and if agency staff were used they had experience of working in the department ensuring continuity. Staff were offered additional hours and overtime.
- We were told about a recruitment day for nursing staff in March. This was a one stop shop for recruitment with interviews on the day with support from human resources and occupational health

Radiology

- The CT (computed tomography) staff were rotational and there were five other staff for the other radiology services. Some of these staff were permanent and some were rotational.
- There were rotas for the radiology staff; the band five staff worked on a 19 week rolling rota and the band six staff worked on a five week rolling rota. There were dedicated night staff and no on call rota. The rota had been brought in following consultation with staff who told us that there was a good work life balance and that they were aware of their work patterns allowing them to plan ahead.
- There were two floating weeks on the rota which allowed managers to cover sickness and absence, annual leave and training. Staff also worked weekends on the rota.

Medical staffing

- Consultants reported no gaps at consultant level and clinics were consultant led. Consultants shared a secretary.
- There was no radiologist cover at Rochdale.

Major incident awareness and training

- There was a major incident policy with detail about the suspension of OPD clinics in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We rated the out-patient and radiology service at Rochdale infirmary as good in the effective domain. The trust were reviewing National Institute of Health and Social care excellence (NICE) guidelines and other guidelines as part of a review process.

Staff development was encouraged and there were opportunities for further education. Appraisal rates were 100% for staff in outpatients (OPD) and radiology and there was good documentation to support this. The diabetes service was using shared care guidelines for positive patient outcomes and a nurse in the diabetes service was involved in research and had won awards for her work

There were good relationships between doctors and nurses in the OPD and there was evidence of multidisciplinary working and nurse led clinics.

Outpatients and diagnostic imaging

In radiology there were a number of processes to ensure consistency of reporting and discrepancy meetings to improve patient safety and outcomes. Pathology results and radiology results were available to staff through an electronic system.

Some radiology and pathology services and were available seven days a week 24 hours a day.

New to follow up rates for outpatient appointments at Rochdale were lower than the England average which meant that patients were discharged in timely way and there was capacity for new patients.

Evidence-based care and treatment

- Staff were aware of the National Institute for Health and Care excellence (NICE) guidance and there was evidence of reviews and audits of guidance and guidelines in the minutes of meetings.
- The trust action plan for the misdiagnosis of cancer included development of a trust wide policy incorporating NICE guidelines and national patient safety agency 16 guidelines- the early identification of failure to act on radiological imaging reports. New standard operating procedures were also in development.
- The diabetes service was using NICE guidance and shared care guidelines for practitioners involved in the care of people with diabetes.
- The trust was using new NICE guidance on new oral anticoagulant drugs that do not require regular blood tests.
- The radiology department held discrepancy meetings to facilitate learning from radiology discrepancies and errors and so improve patient safety.

Pain relief

- Patients attending clinics would bring their own medication that was reviewed by the medical staff as appropriate.

Patient outcomes

- The follow up to new rates for clinic attendances were lower than the England average. New appointments were 29% compared to 59% for follow up appointments. This meant that patients were discharged appropriately and new patients were given appointments. These figures did not include patients visiting the anti-coagulant clinics as they may have needed to attend for life.
- All staff in the trust were involved in "raising the bar on quality" which had ten key actions to make the trust and its services the best for staff and patients. These included improving the environment, making sure services were clean and safe, adherence to clinical standards and a focus on care and compassion
- There was an audit schedule for the OPD and for radiology. In OPD this included trolley mattress audits, environmental audits, hand washing and hand hygiene audit. The hand hygiene audit target was 90% though the department usually scored 100%. In the hand wash audit the department scored 100%. The department scored 94% in the environmental audit the target was 85%.
- In radiology there were audits including hand hygiene audits, dose level audits and room hygiene audits. The x ray room scored 88% in the hand hygiene audit, the target was 90% and actions were put in place.
- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme.

Competent staff

- The trust were supportive of further education and some of the nurses that we spoke to had their degrees funded and were given time to attend university.
- Unqualified staff were encouraged to do a vocational qualification to develop and assess their competencies. This was a five day course and successful participants gained a certificate and a qualification in care.
- Staff said that there were good opportunities for staff development. One of the domestic staff had expressed a wish to work in the department as a health care assistant and was encouraged to apply for a vacancy. They were successful in their application.
- There were link nurses who took the lead in different areas including palliative care, infection prevention, audits, moving and handling and point of care testing. Some of them delivered training in their specialist area.
- The senior ward managers had one to one meetings with their line manager.
- Appraisal rates in the OPD were 100% and were used as an opportunity to discuss staff development and opportunities for learning and development. .

- Radiology staff peer reviewed and audited each other's reports on a three monthly basis to ensure consistency in reporting
- There were monthly CPD sessions for the reporting radiographers.
- There was in house training for radiography staff where possible.
- An e-learning package had been produced by the department for non-medical referrers for radiology services; this was described by staff as practical and informative.
- There was protected time for staff training in the booking centre for two hours per week. Appraisal rates were 100%.
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Multidisciplinary working

- There were good relationships between the doctors and the out-patient staff. There were also specialist nurses who had their own clinics including a colposcopy clinic,
- Occupational therapists and physiotherapists worked together to support the orthopaedic clinics.
- The anti-coagulant staff worked effectively with the consultant haematologists. Staff described good two way feedback with the doctors that could prevent a delayed discharge

Seven-day services

- There was not a seven day service at Rochdale in the OPD. There were some OPD clinics on evenings and on Saturdays but these were to address waiting list initiatives.
- There was a seven day service for x rays for in-patients and out -patients.

Access to information

- The trust used an electronic system which was a web based application that allowed clinical staff to log into a number of different systems at any one time using a single sign in with a password to check on the records of patients. This included requesting and reading radiology and pathology reports and electronic discharge summaries for patients.
- Pathology results were available on line through the trust intranet system.
- The trust used an electronic system for medical records and consultants were issued with hand held electronic devices in case there was any failure in the system.
- There was a diabetes management information technology system which allowed the viewing and sharing of images in the podiatric service in acute and community settings. The images were photographed by a medical illustrator and could be viewed across the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date policy that covered consent, mental capacity and deprivation of liberty safeguards (DoLS), which was accessible to staff on the intranet and staff knew how to find it.
- Training for mental capacity act and DoLS was part of the level two and level three safeguarding training

Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatient (OPD) and radiology service at Rochdale hospital as good in the caring domain.

- There was a trust wide approach to encourage staff to think about compassionate care in all their interactions with patients and the patients we spoke to said that care was good in the department. A patient described staff as courteous.
- The department had scored well in the family and friends test.
- The radiology department had undertaken a patient experience survey in X ray with positive results.

Compassionate care

- One of the ten "raising the bar on quality" actions included compassionate care. Staff were encouraged to think "compassion" in every action and interaction and to be approachable and respectful**.**
- Chaperones were available to support patients in clinics and during procedures if necessary, there was a chaperone policy on the trust intranet.
- We spoke with a patient who was attending the OPD for the first time; she said that the staff were lovely and that

she had no complaints about the service. She also attends a clinic with a relative and that the service that they had received was efficient and that staff were very courteous.
- We spoke with another patient who gave the service ten out of ten.
- A patient attending the fracture clinic said that the doctors were great and that she had never been kept waiting when attending for an appointment.
- In the friends and family test for the department, 87% of people said they would recommend the OPD.
- In the patient-led assessment of the care environment (PLACE) the OPD had scored 93% for privacy, dignity and well-being, the national average was 90.3%.
- Feedback cards and comment boxes were available to use throughout the department.
- A member of staff was rostered to wait in the clinic until the last patient had gone home. These patients were usually older patients using the patient transport services. Staff ensured that they had received refreshments while they were waiting.
- The radiology department had undertaken a trust patient experience survey in x ray. Out of a survey of 216 patients, results showed that 69% of people had an excellent experience and 29% had a good experience.

Understanding and involvement of patients and those close to them

- Patients were involved in decisions about their care. Staff ensured information about care and treatment was provided and understood. They gave additional support or time when needed. We observed patients and their carers being given information about their care and treatment and offered time to ask questions.
- We saw staff helping and supporting patients and their carers in the clinics.

Emotional support

- All out-patient clinics had at least one member of qualified staff who would break bad news and support patients if necessary.
- The link nurse for palliative care would provide support to patients attending clinics at the hospital.
- Staff in the clinics were supportive of each other if they were involved in difficult emotional situations.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic service Rochdale Infirmary as good in the responsive domain. This was because

- Medical staff attended the weekly tracker meetings, this was described as good practice.
- There were a number of nurse led clinics and one stop and rapid access clinics for patients
- There was no reporting backlog for any of the modalities for radiology. The patient tracking list group was chaired by a clinician and addressed individual patient issues along the cancer pathways.

However

- The did not attend rate was higher than the England average and there were no plans in place to address this.
- The trust had no mechanism to measure the number of patients waiting more than 30 minutes to see a clinician.

Service planning and delivery to meet the needs of local people

- Consultants said that the choose and book system for appointment booking for patients worked well. The highest number of appointments was in the anti-coagulant clinics, followed by trauma and orthopaedics.
- There were a number of nurse led clinics including colposcopy clinics.
- There were one stop clinics including urology clinics where patients had all their tests and their consultations on the same day. There were also rapid access clinics.
- There were 7500 patients attending the anti-coagulant service in NMGH and Rochdale. These clinics were for new or unstable patients, patients who required an interruption in their treatment and those who needed transport to the hospital. Other patients were seen at the community clinic of their choice.

Outpatients and diagnostic imaging

- The trust were working with commissioners to roll out the new anti-coagulant drugs that do not require regular blood tests, patients would not have to attend the hospital or clinics as frequently.
- The trust used patient group directions to supply prescription only medicines to certain groups of patients without prescriptions following appropriate training. This allowed timely prescribing of medicines for patients**.**
- At Rochdale there was a computed tomography (CT) scanner that was open between 8 am to 5pm Monday to Friday and a magnetic resonance (MR) scanner which was open 8am to 8pm Monday to Friday. Extra capacity in MR was provided by a mobile scanner which was open 8am to 8pm.
- There was new digital x ray equipment providing digital images in a timely way.
- There was no radiologist on site but there was a reporting radiographer who could report on x rays in the absence of a radiologist. There was also no picture archiving and communication system (PACS) manager on site but this was managed through a link with the radiology department at North Manchester general hospital.
- There were no pathology services on site and any blood tests were sent to Oldham hospital. They were collected by porters during the day before being put onto the transport. The last collection was at 6.20 pm.

Access and flow

- OPD clinics started at 8.30am and finished at 5pm. Consultants could adjust the length of appointments to accommodate new patients and follow up appointments. If clinics were cancelled it was due to lack of consultant cover, clinics were never cancelled due to lack of nursing cover.
- The referral to treatment waiting times for January 2016 were 96.1% of patients were seen within 18 weeks with half of the patients seen in six weeks. In November and December 2015 this figure was 98%. The operational standard was 92%.
- The above figures have been provided by the Trust at the time of the inspection; however we have subsequently learnt these may be unreliable and are therefore not assured that performance is at this level. We are now working with Trust to validate this information and follow up any actions arising.
- The trust had monthly referral to treatment times (RTT) meetings and action plans were in place to improve the RTT times in a number of specialities.
- The cancer waiting times for the trusts were better than the England average. 96.5% of patients were seen within the two week waiting time for cancer compared to the England average of 94.8%. The 31day to 1st treatment target was 99.4% compared to the England average of 97.9% and the 62 day target for referral from G.P.to treatment was 88.8% compared to the England average of 83.5%.
- The did not attend rate (DNA) for the hospital was 11%, the England average was seven percent. The trust did not have a plan in place to address this.
- There was a booking centre for all appointments in the OPD, this was based at Rochdale. The staff worked in specialty/ pathway teams with a co-ordinator tracker to track referral to treatment times (RTT) for their speciality. The teams met weekly and the pathway co-ordinator fed back any problems to the clinical teams any problems with RTT. The process engaged with clinicians as trackers attended directorate meetings; the tracker would inform clinicians of the impact of actions that could lead to the cancellation of clinics e.g. annual leave booked at short notice. The engagement of clinicians in this process was described as good practice.
- Clinics sometimes ran late, consultants said that clinics could run up to two hours late. Patients were informed of the delay when they booked into clinic but this information was not always written up on the whiteboards. The trust had no mechanism to measure the number of patients waiting more than 30 minutes to see a clinician or the proportion of clinics starting late.
- If a clinic needed to be cancelled the consultant's secretary would complete a form and send it to the team. If this was short notice, staff would try to contact patients or letters would be sent by taxi. Only directorate managers were able to cancel clinics according to the trust policy. Clinic cancellations were minimal and had been minimal during the junior doctors' strike.
- There were additional clinics to address waiting lists in the evenings and at weekends. These clinics were usually colo-rectal to meet the demand from the bowel screening programme.
- Delays in the OPD were often due to patient transport services. (PTS) Managers had regular meetings with the

PTS service managers and staff sometimes had to stay late waiting for patients to be picked up. A member of staff was allocated this role on a daily basis ensuring that vulnerable patients were not left alone.

- There was no phlebotomy in–patient service at Rochdale but all the health care assistants were trained in phlebotomy. This meant that they could cover for staff taking lunch breaks or training and patients did not wait long for a blood test.
- New appointments for the anti-coagulant clinic were sent out by first class post to ensure that patients received them in a timely manner.
- There was a did not attend policy for non-attendance at the OPD with exceptions for the two week wait cancer patients, anticoagulation patients, paediatrics, and patients with infectious diseases.
- The department used patient group directions to supply prescription only medicines to certain groups of patients without prescriptions following appropriate training. This allowed timely prescribing of medicines for patients.
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Radiology

- Radiology appointments were arranged from the booking centre by the radiology booking team. There was a standardised booking procedure which gave patients the next available appointment at any site for a radiology test. This reduced the length of time that people needed to wait for a test.
- In January 2016, across the trust, the percentage of people waiting more than six weeks for diagnostic tests and procedures was 6.9%. There were 40 people waiting for an MRI scan and 38 for an ultrasound scan. There were 64 patients waiting for a colonoscopy, 22 for a sigmoidoscopy and 117 for a gastroscopy. This was an improvement on the numbers from the previous month. The trust were aware of the issues and had an action plan to reduce the numbers. This included training nurses to undertake some diagnostic procedures following training and a competency assessment.
- There was no backlog in the reporting of any of the modalities in radiology. This was monitored and the workload was distributed between the radiologists with additional onsite reporting. Some reporting was outsourced. This was part of the response to the missed cancer diagnoses. This had been recognised nationally as good practice.
- The radiology department had high levels of patients who did not attend (DNA) for appointments. The trust did not have a plan to reduce the DNA rate.
- The department monitored the average time from attendance to imaging and the number of appointments attended. This allowed different modalities to benchmark their waiting times against each other.
- There was a reporting radiographer; this ensured that patients received their results in a timely way.

Meeting people's individual needs

- There were 82 languages spoken across the geographical area and there were 107 bank interpreters. Translators were available and we saw evidence that they were used in clinics; they could be booked and would provide face to face translation but if staff were unaware that a patient needed a translator telephone translation was used. Telephone translation was available 24 hours per day. Leaflets were available in a variety of languages.
- There was a Muslim prayer room with a women's area at the hospital.
- Patients with a learning disability had a passport to assist with any communication issues. Patients would be provided with a private waiting room if necessary and were also a priority for the patient transport services.
- There was a bariatric patient treatment couch in one of the treatment rooms
- The consultants used chaperones in their clinics if required.
- There was an anti-coagulant service for housebound patients and patients from the local prison.
- There was a podiatry clinic available across the trust every week day for patients with diabetes. The podiatry staff, including the community staff, had the mobile phone number of the consultant so that they could ring for advice if necessary.
- There was a venesection team for those patients with difficult access to veins, particularly intra-venous substance users. The medical staff said that this was a useful service.
- The patient tracking list was clinically led; it was chaired by the clinical director. The tracking list measured progress on the 31/62 day cancer pathway. It was used to solve individual patient issues on the pathway e.g.

delayed tests or surgery. The meetings were attended by clinicians and consultants and were held at all four sites. The attendance of consultants and clinicians was good practice.

Learning from complaints and concerns

- Patients could access information about how to complain and direct their concerns and complaints either to the hospital complaints department or through the patient advice liaison service. For those patients with a learning disability information in an easy read pictorial format could be provided on 'How to Make a Complaint.'
- Complaints were an agenda item on the monthly directorate meetings which were fed down to the operational managers for feedback to staff. In the first six months of the year, April to September 2015 there were five complaints; these were mainly about staff or procedures in the OPD.
- There had been a year on year reduction in people dissatisfied with complaints in the trust.
- Most complaints about the department were informal and were dealt with by the nurse managers in the departments. Feedback to staff was at the weekly meetings.
- In the radiology department there was very little feedback about complaints and incidents.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the out-patients and diagnostic imaging services at Rochdale as good. This was because

- Local leadership was good with weekly staff meetings that lasted for 15 minutes which staff described as effective.
- The trust was involved in strategic change across the health economy in both health and social care, staff were aware of impending change. Staff, patients and the public had been involved in the development of the vision and values for the trust.
- Doctors and staff said that the trust board was visible and that the culture was open, Management was effective at divisional and local level in the OPD.
- There was good patient engagement at the booking centre with patient representation on forums and at policy review meetings

However

- There was a lack of clarity regarding the management structure and reporting accountability in radiology services amongst staff.
- Sickness levels in the OPD were above the directorate target of five percent but mangers were working with human resource colleagues to address this.

Vision and strategy for this service

- There were strategic changes that the trust was involved in across Greater Manchester in both health and social care. The function of the hospitals in the trust was likely to change as strategic changes were implemented.
- External management consultants had been involved in an option appraisal exercise which included OPD, radiology and pathology services, these services would support any new configuration of the trust.
- There was a vision, values and a strategy for the trust that had been developed with staff, stakeholders and the general public. Poster and pop ups were evident all around the OPD and radiology departments.
- Staff were aware of impending change and were resigned to it. There had been significant change in the trust over the last few years.

Governance, risk management and quality measurement

- OPD, radiology and pathology were part of the support services division. There were quality and performance meetings that were held monthly which were chaired by the director of the division. The meetings focused on targets for all services included in the division and agenda items included patient safety, patient experience, clinical outcomes, performance monitoring, the assurance framework and risks and the risk register. Actions were put in place if services were not achieving targets.
- There was monthly department managers meeting about strategic and operational issues and this fed down to the weekly meetings which were held with OPD staff. This was a 15 minute staff meeting, staff described it as effective and it was well attended. Staff received feedback about incidents and complaints and trust

issues including the team brief. The information was available by email for staff who could not attend the meeting or those who were on long term sick leave. Staff received time in lieu for attending the meeting. It was held on different days so that different staff could attend.
- Consultants met monthly and also held regular audit meetings with the interim medical director.
- There was a departmental risk register for OPD and radiology services. The registers contained actions and target dates for the management/resolution of the risk. Any risk with a significant score was put on the divisional risk register.
- There was a radiation safety group who met every three months, agenda items included equipment, radiation incidents, dose audits and dosimetry for radiologists and radiographers. They produced an annual report.
- The radiology department had a risk register; however there were no risk assessments from the radiation for professionals (RPA).

Leadership of service

- Consultants we spoke with said that the trust board were visible as was the interim medical director.
- Four consultants that we spoke with said that the OPD ran well and that they had no concerns about the service.
- Leadership in the OPD was effective; the matron worked well with the senior staff nurses from all the sites. There was a band seven senior nurse manager who managed two sites supported by a band six nurse at each site.
- There was a ward manager's development programme which was described as useful and good by the band seven senior nurse manager.
- The band 7 reporting radiographer was the nominal manager of the service. They worked clinically for the majority of the time with management responsibilities for half a day per week and the post was a rotational post. There was no band six post and the other staff were band five. Staff said that there was a lack of leadership and managers were not visible at the hospital.
- There was a lack of clear management structure and reporting accountability following management changes in the radiology department in January 2016
- There were no staff meetings for the radiography staff at Rochdale and so there was not a lot of information shared.

Culture within the service

- Staff said that the chief executive officer had provided a culture of openness and that management was visible. They said that they got to know what they needed to know and that the team talks had been inspirational. They also said the Monday message worked to disseminate information. Staff we spoke with said they liked the Monday message.
- Staff said that the culture in the OPD was open and they were happy to raise issues and concerns.
- The human resources service was contracted to an external provider. A manager we spoke with said the service was very helpful and supportive.
- There high levels of sickness in the OPD, they had consistently been at 6% which was above the 5% directorate target. There was a combination of long term sickness and short term sickness and managers were working with the human resources service to manage this. Sickness absence was reported at divisional weekly meetings and there was a sickness absence management group to review, track and improve the management of long term sickness absence.
- Staff morale in the booking centre was good. Staff sickness rates were 4.8%.

Public engagement

- The trust had worked with the public on the vision, values and strategy for the trust; they had used crowd sourcing as a way of obtaining ideas and information from a large group of people.
- There was good patient engagement at the booking centre, there were patient forums and at these events managers from the booking centre explained the booking procedures for patients and for patient transport services. The service had held a desktop review of the elective access policy and there were four patient representatives on a panel of 20 people.
- Staff from the booking service had also attended the cancer patients forum, the Pennine patient user partnership and PAMPER which was a holistic needs group.

Outpatients and diagnostic imaging

Staff engagement

- In 2014, the 'chief executive's challenge' was introduced. Staff were asked to be involved in developing the trust vision and values. This challenge received 27,000 ideas from the workforce. Staff had also been asked to give their views on reducing staff sickness absence rates. The development of the trusts "healthy, happy, here" programme was the result of the 44,000 contributions. The third challenge had recently been completed and led to the development of the 10 "raising the bar on quality" actions.
- Staff awards were held annually, recognising team and individual staff patient care, dedication and innovation.
- There was a Monday message that went out from the chief executive of the trust to all staff. This was generally well received.
- Staff received a monthly edition of 'Team Talk' which was a magazine produced by the executive team to inform staff of the latest news.
- There was a staff bulletin for staff working in the booking centre, it was owned by the staff and covered all roles.
- There was a staff health and well- being plan and staff were offered ten weeks of free zumba classes.

Innovation, improvement and sustainability

- The radiology department had no backlog in reporting in any modalities, this had been recognised nationally.
- The trust had a patient tracking list that was clinically led. This was good practice

Outstanding practice and areas for improvement

Outstanding practice

- The oasis unit was an example of outstanding innovation and service planning to meet both the needs of the local population and individual needs. The unit opened in 2014 and was thought to be the first of its kind in a hospital in England at this time. This unit offered specialist care for patients with delirium or living with dementia during periods of acute illness. The unit was designed to be dementia friendly and offered patient-centred care. The positive impact of the unit had been recognised and was doubling in size as a result of this.
- The Outpatient and Diagnostics department had a patient tracking list that was clinically led.
- The radiology department had no backlog in reporting in any modalities; this had been recognised nationally as extremely good practice.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should continue to reduce the waiting times for the diagnostic procedures of colonoscopy, gastroscopy and sigmoidoscopy.
- Consider the replacement of the allied health professional senior manager for the trust.
- Reduce their did not attend rates in the OPD and in radiology.
- Measure the waiting times for patients in the department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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