Care Quality Commission

Salford Royal NHS Foundation Trust

Salford Royal Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Outstanding ☆
Urgent and emergency services	Outstanding ☆
Medical care	Outstanding ☆
Surgery	Requires improvement ●
Critical care	Good ●
Services for children and young people	Good ●
End of life care	Outstanding ☆
Outpatients and diagnostic imaging	Requires improvement ●

Summary of findings

Letter from the Chief Inspector of Hospitals

Salford Royal NHS Foundation Trust provides both acute and community services to a population of 240,000 people across Salford and the surrounding areas of Greater Manchester. The trust serves a national population for people requiring some specialist care for the treatment of disease or disorders of the brain, skin, renal system, spine and those with intestinal failure conditions.

Salford Royal NHS Foundation Trust employs around 6,600 whole time equivalent staff across both the acute hospital and the community services. Of these staff, there are 730 medical staff, 2,200 nursing staff, 2,000 care support staff and 350 allied healthcare professionals.

We carried out this follow-up inspection in addition to the comprehensive inspection carried out in October 2013. This is because Salford Royal Hospital was inspected during a pilot period when shadow ratings were not published. In order to publish a rating, we needed to update our evidence and inspect all the core services that Salford Royal Hospital provides. At our earlier inspection in 2013, we had not inspected the community services provided by the trust. Our methodology included an unannounced visit to the hospital on the evening of 27 January 2015. We also held a public listening event, where we heard directly from approximately 60 people about their experiences of care.

We have rated this trust overall as outstanding. The Salford Royal Hospital was rated as outstanding and the community services were rated as good. Of the five key questions that CQC asks, we rated the trust as good for being safe and effective, and we rated it as outstanding for being caring, responsive and well-led. In relation to the core services, A&E, medical care and end of life care in the acute hospital and adult services and end of life care in the community were each rated as outstanding.

Throughout the reports for this trust, we refer to the Nursing Assessment and Accreditation System (NAAS) and the trustwide initiative to provide safe, clean and personal care every time (SCAPE). NAAS is a performance framework system designed to help nurses in practice by measuring the quality of nursing care that teams deliver. The NSSA performance assessment framework is based on the trust's own SCAPE approach to service delivery and combines Key Performance Indicators and Essence of Care standards. The framework is designed around 13 standards with each standard subdivided into three elements: leadership, care and environment. The assessment consists of observations of care, asking relevant questions of patients and staff, observing how meals are delivered, and receiving feedback from patients. Wards and departments are rated from red (worst) to blue (SCAPE – best). Where we have reported that wards have attained SCAPE status, this indicates that the ward has been assessed over a period of at least 24 months, and during each assessment, had attained at least a green rating (good). Three consecutive green assessments result in SCAPE status being awarded.

For a ward to achieve SCAPE status, it must, as a minimum, have maintained NAAS (green) for 24 months. Further assessments are undertaken using a comprehensive set of standards for nursing care and the teams can then apply for SCAPE. A SCAPE panel (consists of board members, senior multi-professional staff and a member of the public) then reviews the teams and makes recommendations to trust board that will approve, defer or decline SCAPE status for the applying area.

We rated the leadership of the Salford Royal Hospital as good overall. Three core services each demonstrated outstanding leadership; two core services were rated as good and two core services required some improvements to be made. The leadership of the community services was rated as outstanding overall, and the trust-wide leadership was rated as outstanding. The aggregation of these judgements for assessing the well-led question at provider level is outstanding overall. When we combine the overall ratings of outstanding for being caring, responsive and well-led, it results in the overall trust being rated as outstanding.

Our key findings were as follows:

Summary of findings

Safe:

- The concept of providing safe, harm-free care was considered as a priority by all members of staff. Through the use of quality improvement programmes, we found many examples of how staff had worked together to ensure they provided safe care.
- The use of internal governance systems to ensure safe care was well embedded. Nursing assessment and accreditation systems (NAAS) provided a high level of transparency to the trust's board and to patients in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. Clinical leaders and ward-based staff considered the accolade of SCAPE as significant success.
- The hospital was visibly clean and staff were witnessed to follow appropriate infection control practices. Audits were routinely undertaken to ensure staff complied with local and national policies and action was taken if areas of concern were identified.

Effective:

- Staff based care on best practice guidance. A robust audit programme was in place to demonstrate that action was taken and outcomes monitored to determine effectiveness where improvements were needed. The trust benchmarked itself against a range of national comparators; this demonstrated that the trust generally performed the same as, or better than others in many areas.
- Multidisciplinary working was strongly embedded across the trust. The provision of integrated care through the development of Salford Health Care showed the trust's ability to provide care through multidisciplinary working.

Caring:

- There was a strong emphasis on providing caring, compassionate and dignified care to patients. Performance against national patient satisfaction surveys was consistently good across of all core services, with the exception of services for children and young people, which needed further work to gather feedback from children and their parents/carers.
- People who used the services were actively involved in developing improvements in their care to ensure their care was personal. In January 2013, the trust launched a project aimed at improving the experience of patients, families and carers, as part of the patient experience strategy. This resulted in the concept of 'always events', which were things that patients should always expect to happen to them when receiving care from the trust.

Responsive:

- Services were able to assess and respond to the needs of the population they served. Feedback was gathered from patients and relevant stakeholders to enhance services.
- Provision of religious and spiritual support, and the support of patients during the end stages of life, was noted as being particularly outstanding.
- The critical care department provides a combination of ward, telephone and outpatient multidisciplinary follow-up service. The department contributed to the development of NICE guidelines (2009) on critical care rehabilitation. It proactively gathers feedback on the service for evaluation.

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- The hospital had a multi-faith centre that catered for the religious needs of the local population, including a non-denominational 'Oasis' room.
- A blue butterfly symbol was introduced within the trust to identify people with cognitive impairment. Patients identified as such, were visited by dementia specialist nurses who also co-ordinated training for staff on dementia awareness. All wards had a dementia champion.
- Patient passports were in use across the trust, including passports in different languages.
- The trust had a rigorous complaints answering process to address both formal and informal complaints. Each department had a lead nurse in charge of reviewing and acting on complaints and disseminating the learning from the complaints through safety huddles and newsletters.

Well-led:

- Quality improvement was a clear focus for the trust through collaboration across all staff groups in quality improvement methods to reduce patient harm, and improve outcomes and patient experience. One 'collaborative' focused on gathering patients' views across the whole pathway of care from before admission to the community, to make improvements
- Members of the senior management team were fully engaged with 'front-line' staff. Strong working relationships had been developed between the trust's executive team and the Foundation Trust Governors. Governors were clear about their roles and purpose, which enabled them to contribute to the success of the trust.
- The ambition and vision of the trust to be the safest trust in the National Health Service was understood and embedded in the practices of staff across all professions and at all levels of seniority.
- Staff spoke positively about the engagement of the management team, which enhanced a culture of innovation. High staff satisfaction rates were representative of the positive feedback we received from staff during the inspection.
- The trust had a clear vision and strategy for quality improvement, both within the trust and for working with partners across Wigan, Bolton and Salford and more widely.
- The trust has some of the best scores in the country on the staff survey, reflecting the positive culture in the organisation.

We saw several areas of outstanding practice including:

- Nursing assessment and accreditation systems (NAAS) provided a high level of transparency to the trust's board and to patients in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider and scrutinise.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. The accolade of SCAPE was seen as significant success by clinical leaders and ward-based staff.
- There was clear evidence that the development of the 'emergency village' with its integrated care pathway approach, including medical in-reach, continued to deliver improved outcomes for people.
- Quality improvement initiatives had successfully led to a reduction in the number of hospital acquired pressure ulcers.

Summary of findings

- Staff were encouraged to undertake research. For example, we reviewed a paper published in respect of improving patient care in a national intestinal failure unit.
- The surgical division celebrated its positive arrangement for moving elective orthopaedic work off site, and anticipated that this would improve patient throughput, standardise use of prosthetics and develop a centre of excellence.
- The surgical division indicated it had established a link with Central Manchester NHS Foundation Trust, which it anticipated could lead to future partnership working in the developed Manchester Orthopaedic Centre. This was expected to lead to increased pooled volumes of specialist activity with standardised practice leading to improved patient outcomes.
- The surgical division's annual plan described the development of a service model for emergency and complex surgery with two other NHS providers.
- We saw in the theatre staff newsletter for December 2014 an introduction to the forthcoming 'Theatre Improvement Programme'. We were told this was due to start at the end of January 2015, with the aim of ensuring that theatres could provide safe and reliable care, provide value and efficiency and deliver a high team performance with high team morale and wellbeing. This work was being co-ordinated and delivered through a Quality Improvement methodology, led by a steering group headed by the Director of Organisational Development and Corporate Affairs. We saw from information provided to us that the programme was based around the Productive Operating Theatre model, developed by the NHS Institute for Innovation and Improvement.
- The senior managers within the surgical directorate recognised the areas for further focus, which included interventional radiology, middle grade recruitment to medical staff, the delivery of complex emergency care and making improvements to the discharge process, by reviewing and enhancing the patient pathway.
- There was an incentive for staff who wished to be involved in helping the trust to make financial savings to the service. If an idea was adopted, the staff member received 10% of the overall savings as a reward for their innovation.
- Junior staff were rotated to other areas across the critical and high dependency care units to facilitate personal progression and encourage staff retention.
- Bleeps were provided to relatives so that staff could contact them quickly if they were away from the CCU.
- The diabetes outpatient service demonstrated good practice where children in transition from young people to adulthood were seen in a clinic attended by an adult physician and adult specialist nurses, giving dietetic and psychological support. This ensured a continuous and consistent pathway of care through to adulthood.
- We were told the trust was actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. The trust had piloted the use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB), which were used to support patients that are assessed as acutely unwell deteriorating, with limited reversibility and where recovery is uncertain. However, it was decided not to continue to implement the ACB after the pilot.
- Other improvement areas include Advance Care Planning (ACP), EPaCCS, rapid discharge pathway, meeting the priorities for care of the dying person and effective care after death, including bereavement and mortuary service.

Summary of findings

- Innovative work undertaken included the access to seven-day Specialist Palliative Care for SRFT since 2009 (only 21% of trusts deliver this nationally). The trust has participated in all four rounds of the NCDAH and was described as above the national average for nine out of 10 Clinical KPIs. The bereavement care delivered across the trust and the trust's awareness around the cultural needs of the population were well met by the HSPC, bereavement and the chaplaincy teams.
- The system of daily safety huddles, and intra-team situation reports ensured that important information was passed between teams and shifts.

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

Action the hospital MUST take to improve

- The trust must take action to ensure that WHO safety checks (or equivalent) are conducted on all patients going through operating theatres and it must take action to ensure that monitoring of WHO safety checks are carried out.
- The trust must ensure that the environment is appropriately maintained and fit for purpose; the main outpatient department experienced a regular leaking roof in several areas, and sewage leaks through the ceiling.

Action the hospital SHOULD take to improve

- The trust should ensure that safety checks on technical equipment used in the delivery of treatment and care to patients are carried out routinely. This is something that is required as part of Regulation 16, safety, availability and suitability of equipment. It was considered that the omissions related to the checking of anaesthetic machines by theatre staff were not proportionate to support a judgement of a breach of the regulation.
- The trust should ensure that the knowledge and application of the Mental Capacity Act and the Deprivation of Liberty Safeguards is consistently applied across all services.
- The trust should consider prioritising the improvement of the discharge process for patients from beyond the local area to the wider geographical area.
- Whilst we acknowledge that the trust has embarked on a programme of quality improvement within theatres to improve the culture and morale of the department, the trust should ensure that this initiative is both effective and sustainable so that changes are fully embedded for the future.
- The trust should consider ways of reducing the rate of surgical procedure cancellations.
- The trust should consider a unified strategy for the delivery of children's services, both medical and surgical. Governance systems, risk management and performance measurement processes should be standardised to ensure that children receive quality, evidence-based care.

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	Outstanding ☆	Overall, we have rated the accident and emergency department (A&E) at Salford Royal hospital as outstanding. The staff who worked in the department displayed a true multi-disciplinary approach to caring for their patients. Staffed worked cohesively together, respecting each other's skills, experience and competencies in an enthusiastic and professional manner that benefited the patients they cared for. The service had recently been re-modelled and an improvement plan had been developed and implemented in conjunction with partners in the wider healthcare economy such as GP and clinical commissioning groups (CCGs). Careful consideration had been given to the design and layout of the department and staff were consulted and involved in the development of the improvement plan. A series of process changes and initiatives had been introduced and many were still subject to on-going evaluation. All were geared to improving the patient flow and experience through the healthcare system both prior to, during and after discharge from A&E. From our observations and from talking to staff and patients, the changes, such as physically separating the minors area and establishing it as a predominantly emergency nurse practitioner-led service, had significantly improved the service to those patients. More specifically in terms of their waiting times. Also working particularly well was the 'emergency village', which brought together the A&E and emergency assessment unit (EAU) not just physically but also in terms of the integration of the patient pathway through the emergency medicine division. Our discussions with staff and evaluation of documentation revealed an open and transparent culture within the department with regard to the management of risk. Staff were prepared to report accidents and incidents; incidents were investigated impartially, with an emphasis on quality and service improvement. As part of its commitment to the trust's wider quality strategy, the A&E was actively involved in the

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collaborative work that was looking in real time at patient experience using the patient experience tracker (PET). The PET collects, assesses and tracks patient experience in real time and tracks whether real improvements are being delivered. The results were reviewed by the Matron who worked in the A&E team to make improvements to the environment and clinical practices. This work was further strengthened by the Nursing Assessment and Accreditation System (NAAS), which was based on the trust's Safe, Clean, and Personal approach to service delivery and was used to provide evidence for the Care Quality Commission's assessment. Each ward area had been assessed and was then accredited with a level of compliance rated red, amber, and green or blue. The current rating for the A&E was green, having last been assessed in November 2014.

Feedback from patients and relatives regarding their care while using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place to thoroughly investigate those concerns and we saw evidence of subsequent apologies being made where the service was at fault. There was a culture of learning from complaints and concerns, with the aim of improving the service delivered. Staff were observed to engage with people in a respectful, compassionate and caring manner. Examples of comments made by patients and relatives were "I would drive 50 miles south to pick up my mum so she could be treated here" and "Everybody cares. They (nurses and doctors) go above and beyond especially when they are busy".

While the hospital did not provide any maternity services, A&E staff were able to describe the systems and processes for managing patients who presented at the department with an obstetric-related problem.

Medical care	**Outstanding**	☆	We found that patients were protected from avoidable harm and abuse within the medical division at SRFT. Overall we rated this service as outstanding for this key question, as the concept of 'safe' was clearly so firmly and consistently embedded throughout the division.

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Standards of hand washing and cleanliness were consistently high and regularly audited. The concept of reporting incidents was embedded among nursing and allied health care professionals. When this system was not utilised, there were other channels by which concerns could be, and were, raised. We found that the trust took a proactive stance towards resolving any issues that had the potential to impact on patient safety, and staff were clearly attuned to the expectation that potential safety concerns should be raised immediately and without fear of retribution. Quality improvement strategies were developed and outcomes were closely monitored to ensure patients received harm-free care.

Medical care services at Salford Royal were rated as good in terms of delivering effective care. Use of NICE guidance was widespread and national and local guidelines were easily accessible on the trust's intranet. All national audits relevant to the medical division had been contributed to, and the trust was able to provide evidence of changes made in response to the feedback received. It was clear that clinical audit was seen and used as an effective improvement tool.

In line with the rest of the trust, concerns were found during our inspection regarding the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS). The trust had already taken steps to address this at the time of our unannounced inspection.

Overall, we judged medical care services to be caring. Patients received compassionate care and were treated with dignity and respect and their privacy was preserved. The patients and relatives we spoke with said they felt involved in their care and were given adequate information about their care and treatment. Feedback from patients and their relatives told us that they felt psychologically supported by hospital staff. Patients felt very happy about how they were looked after and complimented the staff looking after them.

The trust has a higher response rate to the Friends and Family test than the England average. The scores have become higher this year than last. This is an important feedback tool that supports the principle that people who use NHS services should

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have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family Test highlights both good and poor patient experience.
Medical care provided at Salford Royal was responsive to patients' needs. The acute medical unit was well-established and led the way in embracing the national four-hour target as 'everyone's business' and not just the responsibility of the A&E department. Extensive work had been undertaken to reduce avoidable admissions and improve early discharges. Although out-of-hours transfers still occurred, these were kept to a minimum and reported to senior team members. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result.
Medical care services at Salford Royal were exceptionally well-led. Clear accountable governance structures existed and risks were identified early and owned by individuals who were appropriately held to account. The culture within the division was one of openness and honesty. The trustwide objectives (Safe, Clean and Personal) were well-known by all levels of staff, and individual divisions had aligned their priorities to the wider goals of the trust. Staff development was seen as a key driver of improvement and there was evidence of widespread investment in staff, encouraging loyalty and engagement at all levels. This meant that staff were empowered to identify areas to improve within their own service.

Surgery **Requires improvement**

We have rated surgery as requiring improvement. We noted that there was a distinct variance between the management of surgical wards and the management of the theatre department.
Ward-based staff followed local systems and processes to ensure that patients were kept safe and were protected from harm. However, within the theatre department, we found that while there were systems in place to protect patients, there were some omissions by staff with regards to implementing these systems and processes. For example, theatre staff were not always completing checklists based on the World Health Organisation

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(WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. Furthermore, there was no monitoring of this by senior staff. The trust had acknowledged some cultural and morale difficulties within the theatre department and had embarked on a quality improvement project to address the issues.

We found that systems and processes were in place for ensuring that patients were kept safe in all the wards we inspected within the surgical divisions. We saw on our visits that 10 of the 12 surgical wards had achieved SCAPE (Blue status) with the exception of B6 (triple green) and the Trauma Assessment Unit (amber). Theatre recovery had also attained a blue SCAPE rating. SCAPE rating was deemed to be the optimal achievable score.

The incident reporting process was embedded in staff practice. Sharing information, including learning from incidents, took place through a number of methods, ensuring that staff were fully informed and aware. Staff received mandatory safety training to support the delivery of safe care and treatment to patients.

The surgical divisions reviewed mortality and morbidity outcomes in order to identify where changes in practice were required. Staff continuously monitored their performance against required safety parameters in respect of patient safety and risks. Where risks to patients were identified, these were acted on. Staff monitored patients' wellbeing in line with an early warning system, which was acted on where concerns were identified. There were effective arrangements in place to minimise risks of infection to patients and staff. Arrangements were in place to ensure sufficient numbers of staff were on duty to support the delivery of patient care safely.

Patients were assessed, treated and cared for in line with professional guidance. There were effective arrangements in place to facilitate good pain management and to monitor this. The nutritional needs of patients were assessed and patients were supported to eat and drink according to their needs. There was access to dieticians and the speech and language therapy team. Complex nutritional needs were addressed through experienced and suitably

skilled staff. Patients' surgical outcomes were monitored and reviewed through formal national and local audit. Staff caring for patients undertook training relevant to their roles and completed competence assessments to ensure safe and effective outcomes for patients. Staff received feedback on their performance and had opportunities to discuss and identify learning and development needs. Consultants led on patient care and there were arrangements in place to support the delivery of treatment and care through the multi-disciplinary team and specialists. There was access to most allied services out of hours.

Critical care

Good

Overall, we have judged this service to be safe, effective, responsive, caring and well-led.
We found disparities in the way that patients' mental capacity was assessed and managed in the unit. Records demonstrated a variance in practice throughout the unit. Some patients had received appropriate MCA assessments and had gone on to have the appropriate DoLS (deprivation of Liberty) assessment in place.
At the point of admission to the critical care unit, staff carried out a total of six risk assessments within the first 24 hours; two assessments were undertaken within the initial two hours of admission. We were told that a total of 74 risk assessments were completed within 72 hours of admission and that staff received an email reminder to ensure the process was completed. However, when we looked at specific records we found disparities in the information recorded. The staff were very focused on delivering care as per trust's ethos and wanted to deliver the best care possible. Documentation targets were continuously met, but the quality and consistency of the information recorded did not always reflect the status of the patient. Staff throughout the unit struggled to find the documents in a timely manner. The EPR system was fully integrated, but the unit still used a paper-based clinical observation document.
The National Intensive Audit and Research Centre data (ICNARC) indicated some concerns regarding delayed discharges, out-of-hours discharges and late readmissions on the unit.

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Incidents were reported and acted on, and were used continuously as a service improvement tool. Safety thermometer data was collected and displayed in public areas for patients and relatives to view. The data collected showed evidence of harm-free care in the unit. All the areas we viewed were clean and tidy and we observed staff adhering to infection control policy. Staff reported having an adequate equipment supply to meet people's needs and we saw documentary evidence that this equipment was regularly serviced.

We found appropriate measures in place to ensure the safe administration, storage and returns procedures for medication. There was an adequate number of nursing and medical staff to provide a seven-day service and an appropriate major incident policy was in place.

The unit participated in local and national audit and had employed three members of staff whose sole purpose was data collection. Unit policies reflected national and best practice guidance and we found the care delivered was evidence-based. Patients had their care needs risk-assessed and had their individual preferences taken into consideration during care planning.

There was a great emphasis on the MDT (multidisciplinary team) approach to delivering care, which was provided seven days a week. Staff underwent a hospital induction as well as a local induction to the clinical area. They were provided with a mentor, annual appraisal and supervisions. We found a sufficient number of clinical and nursing staff to meet patients' care needs.

We found evidence of good quality care being delivered on the units. Patients were well presented and covered up to ensure their dignity was not compromised. The staff interactions with patients and their relatives were observed to be kind and compassionate. Relatives we talked with were very complimentary about the staff, and the service their loved one received. The unit provided adequate emotional support for patients by referring to the hospital psychological service, using clinical nurse specialists and the chaplaincy. Patient survey data demonstrated that 90% of those surveyed would recommend the unit.

Summary of findings

The service was found to be responsive to patients' needs and took account of complaints and suggestions.
Salford Royal NHS Foundation Trust was found to have an effective governance board. Staff had confidence in the way matters were reported handled, learned from and disseminated. Staff reported feeling very involved in the governance process, risk management and quality improvement - not only from a departmental perspective, but from a trust perspective. Meetings were minuted and had clear action plans that presented a thorough audit trail.
There was an important emphasis on staff and public engagement. Staff told us they felt valued, were consulted continuously, and were proud to be able to influence organisational change. Members of the public were able to engage with the trust by leaving feedback from their experiences, either formally or through social media. We noted several suggestion boxes in the appropriate areas and posters encouraging feedback around the unit. The people we spoke to said they felt very confident that they could raise concerns or make a suggestion.

Services for children and young people

Good

Overall, we have rated this service to be good. The service was delivering care that was safe, effective, caring and responsive to the needs of children and their families. There was, however ,some disparity between the overall strategy and vision with regards to the provision of care to children at Salford Royal Hospital, and further work was necessary to strengthen this to ensure the service remained viable for the future. The disparity was in part, due to the existing clinical and operational structures of the hospital. We found that where services routinely treated children, such as the PANDA unit, which was managed by the children's services directorate within the Salford Health Care division, the governance arrangements, risk management and the measurement of performance was suitably robust. But this was not necessarily the case for the relatively low number of children who attended the hospital annually to undergo routine day surgery.

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While a senior clinician was accountable for overseeing the delivery of care to all children, this oversight was not sufficiently apparent for children requiring surgery.

The low number of children who underwent general anaesthetic at the hospital meant that anaesthetists and other staff in the operating theatres were at risk of not having the necessary regular and relevant paediatric practice sufficient to maintain their core competencies. The trust had acknowledged this as an area of concern in 2013, and had instigated a range of initiatives to reduce the potential risk to children. This included commencement of scenario-based training, as well as ensuring that two qualified anaesthetists were present for any child undergoing a general anaesthetic. The service had good incident reporting systems, which staff were able to describe in detail. Staff were aware of their responsibilities to report incidents. Lessons were learned where incidents had taken place. The department was visibly clean. There were systems in place to ensure that patients were protected from the risk of harm associated with hospital acquired infections. Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

There was evidence that staff used a range of local and national clinical guidelines to assist in delivering evidence-based care. The service was recognised as being a leader in the provision of diabetes care to children and young people. Patient outcomes and clinical practice were audited to ensure that practice was consistent. Where there had been deviations from clinical guidelines, or where auditing had identified variations in clinical practice, action plans were utilised to ensure a more standardised approach to care delivery. Within the Salford Health Care children's services directorate, we observed strong and effective multi-disciplinary team working among those involved in providing both acute and community-based care to children and their families.

We observed children being looked after in a caring and compassionate manner. Parents and some children spoke about their care and how involved they were with planning it, and how information was shared with them so they could be fully informed

about what would happen to them. Parental involvement was encouraged where children were under16 years of age, in line with national recommendations; this reduced the impact of hospitalisation on younger children.
The commissioning arrangements of children's services at Salford Royal Hospital meant that there were no inpatient facilities. Where children required hospital care lasting more than 24 hours, there were arrangements in place to ensure that they were transferred to an appropriate facility. There were arrangements in place to ensure that when young people required hospital care or admission, this was done in line with local hospital policy and only where the requirement to provide care had been appropriately risk-assessed. Some improvements were required to ensure that there was age-appropriate information available for children scheduled to undergo surgery.
Staff reported that leadership at a local, ward-based level was good; managers were reported to be supportive of their staff and people spoke positively about working at Salford Royal Hospital. Staff visions and behaviours were aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care every time. A small minority of staff who worked within the day surgery unit reported that improvements could be made to ensure that they received the necessary amount of sustained and consistent support from managers.

End of life care

Outstanding ☆

The hospital's Specialist Palliative Care(HSPC) team provided face-to-face support seven days a week, with the hospice providing out-of-hours cover. There was strong clinical leadership of the HSPC team resulting in a well-developed, strong, motivated team. A strong bereavement team was available to support carers and families following the death of their relative. The teams worked well together to ensure that end of life policies were based on individual need and that all people were fully involved in every part of the end of life pathway. Relatives of patients receiving end of life care were provided with free car parking and open visiting hours. Families were offered 'keepsakes' including fingerprints, photographs and locks of hair. Families were given the choice of how their relative was

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moved to the mortuary. Relatives received their family member's belongings in canvas bag with a 'swan logo', which highlighted to staff that people carrying the bag may need extra support. There was excellent spiritual/religious awareness across the hospital and facilities were in place to support the different cultures and religions of the people of Salford.
End of life care was embedded in all the clinical areas and staff we spoke to were passionate about end of life care and the need to ensure that the wishes and preferences of their patients and families were met as they entered the last stage of their life. Palliative care link nurses were introduced onto the wards to champion good end of life care.
There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their Preferred Place of care(PPC) or Preferred Place of Death(PPD). Patients were discharged within a six-hour window.
Patients were cared for with dignity and respect and received compassionate care.
Medicines were provided in line with guidelines for end of life care.

Outpatients and diagnostic imaging — **Requires improvement**

The premises were mostly appropriate for the service they were providing, although the main outpatients department required an upgrade in design, as the fabric of the building provided challenges for staff as the ceiling occasionally leaked from the soil pipe.
Where issues around capacity had been identified the trust had responded to reduce the impact on patients by providing extra clinics. However, there were improvements to be made around waiting times in some specialities. There was scope for a more consistent and sustained level of achievement in meeting targets for referral to treatment times on the 18 week non-admitted pathways.
There had been an issue around the reporting times in magnetic resonance imaging (MRI) scanning. Although staff had taken steps to mitigate a build-up of unreported scans, the measures taken could not be sustained in the long term with existing staffing levels and methods of working. The trust was in the process of reviewing the staffing levels and productivity in the radiology department.

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There were concerns during our inspection around the safety of staff working alone in the outpatient ambulance wait lounge and the ability of staff to ensure that patients' care needs were met in the lounge when they working alone. However, this issue was raised during the inspection and service managers had mitigated the risk immediately following our inspection.

Staff were kind, attentive and spent time ensuring that patients understood what their appointment involved and what their treatment plan was. Where necessary, people were assisted around the department.

Leadership at all levels was visible and engaged with operational staff. Staff reported feeling supported and encouraged to innovate.

Salford Royal Hospital

Detailed findings

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

Contents

Detailed findings

Background to Salford Royal Hospital

The trust is an NHS Foundation Trust that is an integrated provider of hospital, community and primary care services.

The trust revenue is £449 million and until this financial year had shown a surplus; the trust currently has a small deficit.

At the time of the inspection there was a stable executive team. The CEO had been in post for twelve years and the Executive Nurse Director/Deputy CEO joined Salford Royal Hospital in 2004.

The Chair was appointed as a Non-Executive Director at Salford Royal NHS Foundation Trust in November 1999. He was appointed as Chairman on 1 July 2008.

Salford Royal Hospital has 839 beds of which 38 are designated critical care beds. Services for children do not include inpatient beds although there is a Paediatric Assessment and Decision Area (PANDA) unit attached to the accident and emergency department. Some children's day surgery is carried out at the hospital.

Salford District is ranked 26 out of 326 local authorities in the Indices of Multiple Deprivation putting it well below the England and regional averages for indicators such as life expectancy.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission.

Head of Inspection: Heidi Smoult, Deputy Chief Inspector of Hospitals, Care Quality Commission

The team consisted of 54 individuals and included CQC inspectors and managers and a variety of specialists including doctors, registered nurses, a student nurse, therapists, experts by experience and senior NHS managers.

How we carried out this inspection

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

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

The inspection team inspected the following seven core services that are provided by Salford Royal Hospital:

- Accident and emergency services
- Medicine (including care of older people)
- Surgery
- Critical care
- Services for children and young people
- End of life care services
- Outpatients

Prior to this inspection we reviewed a range of information we held about the trust. We reviewed the information from organisations that had shared what they knew about the trust with us prior to the inspection in October 2013. These include the Clinical Commissioning Groups (CCG's) that contracted with the trust, NHS England, Health Education England (HEE), The General Medical Council (GMC), The Nursing and

Detailed findings

Midwifery Council (NMC), the Royal Colleges and Healthwatch. We liaised with a proportion of these stakeholder organisations prior to this follow up inspection.

We interviewed staff and managers, talked with patients and staff from wards and departments across the hospital and also with carers and family members of patients. We observed how people were being cared for and reviewed patients' records of personal care and treatment. We also reviewed information supplied to us by the trust and reviewed data that CQC holds on the trust.

Facts and data about Salford Royal Hospital

Context

- Foundation Trust since 2006
- Around 839 beds
- Serves a population of around 240,000
- Employs around 6,600 whole time equivalent members of staff

Activity

- Inpatient admissions 47,461(excluding day and regular day/nights) between October 2013 and September 2014.
- Total outpatient attendances 397,029 between October 2013 and September 2014
- A&E attendances 92,176 between October 2013 and September 2014

Intelligent Monitoring –

	Items	Risks	Elevated	Score
Safe	8	0	0	0
Effective	31	0	0	0
Caring	21	0	0	0
Responsive	10	1	0	1
Well led	24	0	2	2
Total	**94**	**1**	**2**	**3**

The risk in responsive is for referral to treatment (1 July 2014 to the 22nd July 2014)

The elevated risk in well led is for whistle blowing alerts (18 July 13 to 29th September 14)

Key Intelligence Indicators

Safety

- One never event in last 12 months – In community wrong site surgery (extraction of incorrect tooth)
- STEIS 18 Serious Untoward Incidents (April 2013 - May 2014)

Infections

- C-difficile within expectation
- MRSA one case in September 2014

Effective

- HSMR - 84.8 Better than expected April 2013 March 2014
- SHMI - 94.4 Similar to expected April 2013 March 2014 (October publication)

Caring

Friends and Family Test

- Average score for both inpatients and A&E are similar to the national average for 2013/14
- Response rates for both inpatients and A&E are better than the national average for 2013/14

Cancer Patient Experience

- In the top 20% of all trusts nationally for 26 of the 69 questions

CQC Adult Inpatient Survey

- Trust scored 'better performing trusts' for six out of 10 questions and about the same as other trusts for all other questions.

Responsive

A+E 4 hour target

- Inconsistently met the 95% in the previous 12 months

Referral to treatment

- Did not consistently meet the admitted and non-admitted pathways

Cancer 2 week wait

- Consistently met the national target

Cancer 31 day wait

- Did not consistently meet the national target

Cancer 62 day wait

- Did not consistently meet the national target

Well-led

Staff survey 2013:

- In the top 20% for 23 of the 30 questions with 0 questions in the lowest 20%
- 86% of staff feeling satisfied with the quality of work and patient care they are able to deliver (better than average)
- 92% of staff agreeing that their role makes a difference to patients (better than average)
- 84% of staff having equality and diversity training in the last 12 months (better than average)
- 91% of staff believing that trust provides equal opportunities for career progression and promotion (better than average)

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

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	Outstanding ☆
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆
Overall	**Outstanding** ☆

Information about the service

For the purpose of management and governance the accident and emergency department (A&E) sat in the Division of Salford Healthcare. This division also managed the associated areas of acute and community medicine, intermediate care and children's services.

The A&E department at Salford Royal hospital provided a 24 hour a day, seven-day a week service to the local area. The department saw approximately 92,500 patients from November 2013 to October 2014. The trust had not consistently met the government's target of 95% of patients being seen within four hours of their attendance at the A&E department. Between November 2013 and June 2014 there were times when the department was performing worse than the England average for the 95% target. However, the trust's performance was better than the England average for the July 2014 to September 2014 period.

Patients presented into the department by walking into the reception area or arriving by ambulance by a separate entrance. If a patient arrived on foot, they were booked in by reception before being seen by a senior triage nurse, who would then stream them to the appropriate area. Triage is the process of determining the priority of patients' treatments based on the severity of their condition. If the patient arrived by ambulance, they were then initially assessed by a senior nurse in an assessment area before then being taken to the most appropriate area in the department to receive their care and treatment.

The A&E at Salford Royal consisted of a reception and waiting room area, three triage rooms, a predominantly emergency nurse practitioner led minor injuries area (minors) with six cubicles, two major treatment areas (majors high dependency and majors 2). This included a four bedded initial assessment area along with eight individual bays in a resuscitation room. The department also had three fully equipped rooms which housed the out of hours GP services and a separate room designed for patients for whom a place of safety was indicated under Section 136 of the Mental Health Act 1983.

Children under 16 years attending the A&E department followed a slightly different pathway. They were booked in at reception and triaged as were the adult attendees but were then moved to a paediatric assessment and decision area (PANDA) where they received their on-going care and treatment by appropriately trained staff. During peak periods (between 1pm and 9pm daily) children were triaged by qualified children's nurses. A report on the care of children in the PANDA unit can be found in the Children and Young People section of this report.

Salford Royal is also one of three hospitals forming the Greater Manchester trauma network and is the receiving centre for all non-penetrating injuries.

During the course of the inspection visit we spoke with more than 25 staff comprising consultants, junior doctors, senior nurses, junior trained nurses, healthcare support workers and reception staff. We also spoke with 20 patients, relatives and the parents of three children.

Urgent and emergency services

Summary of findings

Overall, we have rated the accident and emergency department (A&E) at Salford Royal hospital as outstanding. The staff who worked in the department displayed a true multi-disciplinary approach to caring for their patients. Staffed worked cohesively together, respecting each other's skills, experience and competencies in an enthusiastic and professional manner that benefited the patients they cared for.

The service had recently been re-modelled and an improvement plan had been developed and implemented in conjunction with partners in the wider healthcare economy such as General Practitioners (GP's) and Clinical Commissioning Groups (CCG). Careful consideration had been given to the design and layout of the department and staff were consulted and involved in the development of the improvement plan. A series of process changes and initiatives had been introduced and many were still subject to on-going evaluation. All were geared to improving the patient flow and experience through the healthcare system both prior to, during and after discharge from accident and emergency. From our observations and from talking to staff and patients the changes, such as physically separating the minors' area and establishing it as a predominantly emergency nurse practitioner led service had significantly improved the service to those patients. More specifically in terms of their waiting times.

Also working particularly well was the 'emergency village' which brought together the A&E and emergency assessment unit (EAU) not just physically but also in terms of the integration of the patient pathway through the emergency medicine division.

Our discussions with staff and evaluation of documentation revealed there was an open and transparent culture within the department with regard to the management of risk. Staff were prepared to report accidents and incidents; incidents were investigated impartially, with an emphasis on quality and service improvement.

As part of its commitment to the wider trust's quality strategy, the A&E was actively involved in the collaborative work that was looking in real time at patient experience using the patient experience tracker (PET). The PET collects, assesses and tracks patient experience in real time and tracks whether real improvements are being delivered. The results were reviewed by the Matron who worked in the A&E team to make improvements to the environment and clinical practices. This work was further strengthened by the Nursing Assessment and Accreditation System (NAAS) which was based on the Trust's Safe, Clean, and Personal approach to service delivery and was used to provide evidence for the Care Quality Commission's essential standards of quality and safety. Each ward area had been assessed and was then accredited with a level of compliance rated red, amber, and green or blue. The current rating for the A&E was green, having last been assessed in November 2014.

Feedback from patients and relatives regarding the care they received whilst using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place to thoroughly investigate those concerns and we saw evidence of subsequent apologies being made where the service was at fault. There was a culture of learning from complaints and concerns with the aim of improving the service delivered. Staff were observed to engage with people in a respectful, compassionate and caring manner. Examples of comments made by patients and relatives were 'I would drive 50 miles south to pick up my mum so she could be treated here' and 'Everybody cares. They (nurses and doctors) go above and beyond especially when they are busy'.

Whilst the hospital did not provide any maternity services, A&E staff were able to describe the systems and processes for managing patients who presented at the department with an obstetric related problem.

Urgent and emergency services

Are urgent and emergency services safe?

Outstanding ☆

Staff demonstrated an open and transparent culture with regards to incident reporting and patient safety; staff understood their roles and responsibilities and were empowered to raise concerns and to report incidents and near misses actively to promote learning and improvement. Incident reporting was common practice throughout the department and there were examples that staff learnt from incidents, near misses and errors. All staff were encouraged to participate in safety improvement collaboratives through the implementation of local quality improvement projects.

There were systems to protect patients from the risk of abuse and to maintain their safety in line with current best practice guidelines. The safeguarding of vulnerable adults and children was given sufficient priority and staff were supported with this through the adaptation of the electronic patient record system to help alert staff promptly upon the presentation of adults and children who had previously been recognised as possibly being vulnerable.

There were adequate staffing levels to provide safe care to patients. In addition, staff received the necessary training to enable them to carry out their roles effectively. Recognising the national shortage of middle grade A&E doctors, the trust has proactively trained advanced nurse practitioners (ANP) to support the A& E workforce. Senior and junior staff alike spoke highly of the role of the ANP in care provision.

The department had processes in place for assessing patients when they first presented to the A&E and also for monitoring patients when they remained in the department for extended periods of time; patients were escalated to the appropriate clinician as required to ensure they received timely care and treatment.

Risks to safety from service developments, including sudden surges of patients presenting to the department were managed in accordance with local major incident plans which were tested frequently and reviewed periodically.

Incidents

- The trust reported no serious untoward incidents in the A&E department from April 2012 to May 2014.
- All the staff we spoke with knew how to report incidents and "near misses" on the trust wide electronic reporting system and regularly did so.
- All incidents were reported through a centralised system called Datix. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends.
- There was evidence of learning from incidents, not just from within A&E but also trust wide. Staff told us, and we observed, that such information was shared during the shift's 'safety huddles' and also through the dissemination of inter-departmental newsletters and within staff meetings.
- The majority of the 25 plus staff that we spoke with reported that they were supported and encouraged to raise any concerns they may have with the clinical and nursing leads on the department.
- From the medical staff we spoke with we were unable to confirm that regular mortality and morbidity meetings took place on A&E. The goal of such meetings is to take learning and insight from individual cases that have been managed on the department. However, the trust had a system in place for ensuring that all deaths that occurred within the hospital were reviewed by a consultant who was not involved in the care of the patient; outcomes of these reviews were reported to a Divisional Assurance and Risk Committee.

Nursing Assessment and Accreditation System (NAAS) & Safe, Clean and Personal Care Every Time (SCAPE)

- The A&E department participated in the trust wide Nursing Assessment and Accreditation System (NAAS). This is a performance assessment framework based on the trust's Safe, Clean and Personal approach to service delivery and incorporates the Essence of Care standards, key clinical indicators; each question is linked to Compassionate Care (the 6cs – care, compassion, competence, communication, courage and commitment). The framework was based around

13 standards with each standard further sub-divided into Environment, Care and Leadership'. The NAAS was designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements were required. The assessment was carried out on an unannounced basis and involved observation of care and documentation and discussion with staff and patients. Following the review the area being inspected is accredited with a rating which equates to their performance scores and determines their re-inspection frequency. Action plans were required for any shortfalls and these were time bound and monitored by the management team and also reported to the trust board. For the last review of A&E in November 2014 they achieved a green status, which means re-assessment within 8 months.

Cleanliness, infection control and hygiene

- We observed that staff complied with the trust wide policies for infection prevention and control. This included wearing the appropriate personal protective equipment such as aprons and gloves.
- From figures obtained during the visit, 95% of nursing staff working in on A&E had completed infection control mandatory training with 98% also having completed hand hygiene training.
- Bare below the elbow policies were seen to be adhered to by all staff.
- There were adequate hand washing facilities throughout the department with non-touch taps although anti-septic hand gels were not always so easy to find.
- The department had an experienced infection prevention and control lead nurse. Part of their role was to produce a newsletter, which kept staff updated with all infection prevention and control issues. For example, reminding staff about the need to complete high impact intervention audits on hand washing and all aseptic non touch techniques (ANTT).
- There had been no reported cases of MRSA or Clostridium difficile in the department during the past 12 months.

Environment and equipment

- The department had a range of equipment which was seen to be visibly clean and well maintained. Labels were used to indicate when a piece of equipment had been cleaned.
- There was a well-equipped eight bedded resuscitation area which was visibly clean and well organised. The colour coded labelling of equipment in the stacker systems was commendable and enabled easy recognition and access to what might be required in the care and treatment of patients in the resuscitation area. This would be of particular help to any staff who were new to or less familiar with working in the area.
- The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner.
- One resuscitation bay was set up specifically for the management of children. During the course of our inspection we saw a child admitted to the department and managed within this bay. Their care was delivered by paediatric nurses and medical staff who attended the department from the nearby PANDA unit.
- Resuscitation equipment was readily available throughout the department. We saw that it was regularly checked and tested.
- We did find two out of date intravenous cannulae amongst the emergency caesarean equipment pack. These were removed and brought to the attention of the nurse in charge.
- The department also had a specific room for the management of patients presenting with a mental health problem. The room was designed in such a way as to provide a separate, quiet area which offered a degree of privacy and security. The room was also designated as the A&E's Section 136 Mental Health Act room and had been designed to provide a low risk environment (Section 136 of the Mental Health Act 1983 provides police forces with the power to take people to a designated place of safety if they believe a person to be suffering from a mental illness and are in need of care).

Urgent and emergency services

Medicines

- All medicines were stored in locked patient medication lockers, designated cupboards and trolleys or a locked fridge.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers with potassium-containing solutions kept separately.
- All prescribing in A&E was electronic and all patients had their allergy status recorded on the electronic patient record system (EPR). There was a plan to incorporate safety flags within electronic prescribing, however at the time of the inspection, this had not been done yet. Therefore the system would allow staff to prescribe a drug to a patient to which they were potentially allergic to. The trust policy, however, was that it was safer to have a system which did not provide any alerts and required the prescriber to check allergies, rather than a system which provided specific alerts on allergies alone and did not include drug interactions.
- The department used an automated pharmacy dispensing system. Staff told us that they felt this system had definitely improved patient safety. For example, it used finger print technology to control access; it provided an audit pathway and improved inventory control.

Records

- With the exception of some nursing documentation (e.g. the intentional rounding record) all patient records both nursing and medical were electronic. Access to these records was password protected, ensuring the safety of patient records.
- The A&E had been the last of the hospital departments to be assimilated into the EPR system and all the staff that we spoke with reported the benefits. For example, the collection and sharing of clinical information in a fully integrated system.
- The trust's EPR team were continuing to provide training and support to the A&E team as the system was embedded into everyday practice. We saw that the system was continuing to be updated to meet the department's specific needs. For example, the addition of specific care pathways such as for the management of patients presenting with fractured neck of femur injuries.
- We reviewed several sets of patient's electronic records to establish the range of risk assessments being undertaken. We noted assessments for risks such as slips, trips and falls, safeguarding and capacity to consent.
- At the time of the inspection we saw that 95% of the staff had completed information governance training.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse.
- All trained nurses on A&E completed safeguarding children training at level 3 and safeguarding adults' training every 3 years. The department had a safeguarding lead nurse in post.
- Uptake of safeguarding training amongst doctors was at 94% against a trust target of 95%.
- The EPR had a section dedicated to safeguarding. This, once completed, enabled the record to retain any safeguarding history which would then be apparent on any future admission to the hospital. We saw an example of a patient who had previously been flagged at risk of safeguarding issues identified in a timely manner and referred to the adult safeguarding team through EPR and via a telephone call.
- The safeguarding section of the EPR included an assessment of capacity. When completed if the answer to the question 'any safeguarding concerns' or 'any reason to doubt this person's capacity' was 'yes' then the EPR automatically notified the safeguarding team.
- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.

Urgent and emergency services

Mandatory training

- Compliance with mandatory training was monitored very closely using a computerised system. The trust took a position that it was essential for all staff to complete their mandatory training. Failure to attend and complete mandatory training could lead to disciplinary action being taken.
- Figures obtained on the inspection visit showed that for the A&E department almost 90% of staff were up to date with their mandatory training. This included 93% of clinical staff having completed their fire safety training.
- There was a range of mandatory training available which was delivered electronically and via face to face sessions, some of which was annually refreshed (for example, resuscitation, information governance, fire safety and infection control). Some subjects were managed by one off sessions such as naso-gastric tube management and dementia awareness

Assessing and responding to patient risk

- All patients whether attending by foot or by ambulance were triaged by a suitably competent senior nurse. Three adult triage rooms were available adjoining the main reception area and waiting room. Once having been triaged, patients were then prioritised for treatment and clinical intervention in the most appropriate area within the department for their on-going management.
- Triage was undertaken in accordance with the Manchester Triage System. This is a tool used widely in A&E departments to detect those patients who require critical care or are ill on arriving at the A&E. Trained triage nurses followed a pathway or algorithm and assigned a colour coding to the patient following initial assessment.Red being the label assigned to those patients who needed to be seen immediately through to orange (very urgent), yellow (urgent), green (standard) and blue (non-urgent).
- The triage area and the four bays being used for initial assessment of majors were also used to commence investigations that would assist with diagnosis and treatment. For example bloods were taken, electrocardiograms (ECG) carried out, analgesia prescribed and X-Rays ordered.
- Any children attending the A&E were also triaged and whilst this was always undertaken by an experienced A&E practitioner they were not always specifically trained children's nurses. The A&E did have dedicated paediatric nurse triage cover but only currently between the hours of 13.00 and 21.00 which had been identified as the peak period for paediatric attendances to the A&E. At other times, children were triaged by the regular staff who had been provided training on triaging children. Once triaged, children were transferred to the nearby PANDA unit for their on-going care and treatment. In addition, the trust had identified the lack of substantive, 24 hour triage facilities for children by trained children's nurses; this was listed as a risk on the departments risk register as a moderate risk. Controls had been instigated including a review of staffing establishment to determine whether additional qualified children's nurses could be appointed, as well as reviewing the existing triage tool to ensure it was more specific to children.
- In the summary for September 2014, 95% of patients waited under 17 minutes from arrival to initial assessment.
- The department utilised an early warning scoring system (EWS) to detect the deteriorating patient. Information concerning all patients within the department were displayed electronically on large screens through the clinical areas so the senior nursing and medical staff had a real time overview of the dependency of the patients within the department at all times.
- In the event of an adult cardiac arrest in A&E there were sufficient numbers of suitably qualified nursing and medical staff to manage the situation so a cardiac arrest call was not put out to the rest of the hospital. We saw that on each shift the staff nominated to make up the A&E rapid response team were displayed along with their role in the team. For example, one individual

forming part of the rapid response team would be identified as the person responsible for managing a patient's airway whilst another person would be assigned to be the relative's support and liaison nurse.

- The A&E was a major trauma centre and part of the Greater Manchester Trauma Network. Any expected ambulance admissions to the department were announced via the tannoy system indicating their colour status and anticipated time to arrival. This enabled the relevant and appropriate staff to be ready and waiting.

Nursing staffing

- We saw that for each shift the actual versus planned numbers of nursing staff on duty each shift were displayed in accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry. On the days of our visit the actual numbers of registered and unregistered nurses on duty did fall below the planned number of 16 trained nurses. However, such was the skill mix and flexibility of the staff on duty that they were able to deploy themselves as demand and workload dictated so there was no obvious detriment to the standard of care being delivered.
- Generally speaking the department was able to provide its planned 16 trained nurses plus 6 support grades on an early shift. These numbers were augmented by a further two trained and one support twilight shift before handing over fully to the night team at 02.00. There were usually 11 trained nurses plus 4 support staff on night duty.
- The redeveloped minors' area was led by advanced nurse and emergency nurse practitioners with access to consultant advice and support as required.
- At the time of our visit the department was carrying 4 vacancies which were scheduled to be advertised nationally. In total the nursing establishment was 152.31 whole time equivalents. There had been an increase in nursing posts in accordance with the recently implemented improvement plan.
- Bank staff were used to cover any shortfalls in the staffing numbers on a daily basis and wherever possible staff were used who were familiar with the department. Agency staff were used as a last resort only.

Medical staffing

- We examined the medical staffing rota and talked with consultants, middle grade and junior doctors both on A&E and during visits to the Emergency Assessment Unit (EAU).
- We noted that there was 47.89 WTE medical staff working within the department since September 2014.
- Compared with the England average of 23% A&E consultants, the department had a much higher proportion with 46% of the medical staffing being consultant grade. We were told that there were 12 WTE consultant posts but there were plans to increase this number further. There was a shortage of middle grade doctors but this shortage had been off-set by the inclusion of advanced nurse practitioners (ANP) on the medical staffing rota. The skills and competencies of the ANP were greatly valued in the department and provided a solution to the recruitment problems with obtaining junior trainee grade doctors.
- We were told that there were still plans to add to the consultant's establishment so that consultant cover could be provided in the department 24 hours per day, seven days per week. According to the staffing rotas and from our discussions with the medical staff, there were usually three A&E consultants in the department during the day with two in the evenings and then two consultants on call overnight; one for A&E and the other for the trauma team. These numbers were augmented by upper and middle grade doctors.
- The feedback from junior doctors was positive regarding the availability of consultant support, 'if we are busy, consultants will always stay with the team'. We saw evidence of consultant support and involvement in an admission to the resuscitation room during our inspection.

Urgent and emergency services

Major incident awareness and training

- The trust had a major incident plan, which was last reviewed in January 2015. This was available for all staff on the trust's intranet pages.
- Staff that we spoke with had an understanding of their roles and responsibilities with regard to any major incidents.
- On January 5 2015 a gold command presence was established in A&E to satisfactorily manage the A&E pressures at a time when other NHS trusts had declared major incident status for their A&E service in light of the national surge in demand.
- A decontamination room was available in the A&E department although at the time of our visit was being utilised by the portering service.
- We were told that reception and support staff for the A&E and out of hours GP service regularly held training and desk top reviews of their roles and responsibilities in the event of a major incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine (CEM), the National Institute of Clinical Effectiveness (NICE) and the Resuscitation Council UK.

The department had an on-going audit programme which encompassed both local and national audits. Where performance was noted to be below national standards, the department had implemented action plans to improve the care and treatment of patients.

Staff were supported through a process of meaningful appraisal. Furthermore, there were systems in place for ensuring that staff who were newly appointed to the department were supported and that they were competency assessed to ensure they had the skills and knowledge to safely care for patients presenting to the A&E department.

There was strong evidence of multi-disciplinary working especially the integrated ways of working between the EAU and A&E. This working relationship helped to ensure timely and appropriate care and treatment especially for older patients with complex conditions.

Whilst junior medical staff had reported that they had not received any formal training in relation to deprivation of liberty safeguards, staff were able to demonstrate a good understanding of the subject matter and reported having systems in place to help facilitate the assessment of a patients capacity as part of the routine assessment process.

Evidence-based care and treatment

- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine (CEM), the National Institute of Clinical Effectiveness (NICE) and the Resuscitation Council UK.
- Guidelines were easily accessible on the trust intranet page and were up to date. Junior doctors were able to demonstrate ease of access and found them clear and easy to use.
- Adherence with guidelines was encouraged through the development of illness specific proforma's on the EPR system, to prompt use of best practice guidelines. We saw evidence of use of the Fracture Neck of Femur guidelines and sepsis guidelines.

Pain relief

- Each patient's pain score was recorded on the EPR system.
- Triage nurses were able to prescribe analgesia promptly during the patient's journey through the department.
- The Abbey Pain Tool had been introduced to help assist staff to determine pain levels in patients who presented with cognitive impairment.

Urgent and emergency services

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- Vending machines were available in the main waiting area for those patients who had been triaged and who had been assessed as being okay for them to drink whilst awaiting clinical review.
- There was a nutrition and hydration assessment and status report included in the patient's EPR.

Patient outcomes

- The department closely monitored its performance against a range of clinical indicators and presented a monthly report in a dashboard format. This presented a comprehensive and balanced view of the care delivered by the A&E department. It also reflected the experience and safety of the patients and the effectiveness of the care they received.
- The CEM has a range of evidence based clinical standards to which all A&E departments should aspire to achieve to ensure that all patients receive the best possible care to ensure optimal clinical outcomes. The A&E department has participated in a number of audits to benchmark their performance against the CEM standards.
    - Severe Sepsis and Septic Shock Audit - In an audit of patients presenting to the A&E with severe sepsis or septic shock in 2013-2014, the department performed between the upper/lower England quartiles or in the upper England quartiles for all but one of the questions asked. So, for example the results showed that 98% of patients had their vital signs recorded in their A&E notes and 96% were administered antibiotics before leaving the department but only 28% of cases provided evidence that high flow oxygen was initiated in the A&E department. As a consequence of the sepsis audits the department now has a lead nurse for sepsis in post.
    - Fractured Neck of Femur Audit 2012-2013 – in this CEM audit the department scored poorly. Falling into the lower England quartile for a number of questions relating to the prompt administration of analgesia and the on-going management of pain. Also the time before the patient received their X-ray showed that 64% of patients waited between one and two hours. We spoke with staff during the visit to establish what steps had been taken to improve performance since this last audit. It was clear that the fractured neck of femur pathway had been reviewed and changes made to improve performance. These included the use of fascia iliac compartment blocks, establishing an orange categorised patient and improving the access to X-ray. Re-audit had not yet taken place so the anticipated improvements were yet to be ratified.
    - Renal Colic Audit 2012-2013 – the results of this CEM audit showed that for patients assessed as having moderate pain only 47% were provided with analgesia within an hour of their arrival. The CEM standard was 90%. Again much work had been done by the department since this audit to improve outcomes for patients. More specifically, improving access to analgesia utilising the Omnicell system, the introduction of a pathway document and agreement with the Urology team on the type and timing of the appropriate radiological investigations.
    - Consultant sign-off 2013 Audit – the CEM standard states for certain high risk patients (for example, adults with non-traumatic chest pain) they should be reviewed by a consultant before discharge. The results showed that consultants and senior A&E doctors were more likely to actually see this group of patients in person rather than discuss them or review their notes after discharge (positive outcome). The figures from the September 2014 dashboard showed that the number of patients receiving consultant sign off was 81%.

Competent staff

- Annual appraisals of both nursing and medical staff took place and staff talked positively about the process.
- We saw that the A&E had completed 23.5% of its staff appraisal between April and September 2014.
- All new nursing staff undertook a three week induction to the department where they had an opportunity to

work alongside a supervisor and gain an insight into all aspects of the patient pathway (e.g. triage, minors, majors and resuscitation). Once this induction period was completed the new member of staff would be allocated to a mentor group led by a band 7 nurse and worked through a book of competencies, having them signed off as competent only once they had been assessed. This was generally undertaken by the practice educator who was available to offer advice, training and support to all nursing staff within the department.

- 11 members of staff assigned to emergency medicine (accident and emergency) were accredited instructors of advanced paediatric life support. 18 members of staff assigned to Children's Services had undertaken paediatric life support training.
- We saw that development opportunities were utilised for band 7 nurses to engage them in supportive management, practice education and development roles.
- The department had also supported a number of trained nurses to develop their skills and competencies as emergency and advanced nurse practitioners.
- Every trained nurse had undertaken at least intermediate life support with many having also completed advanced life support.
- The junior doctors told us they received regular support and weekly teaching from the A&E consultants to which they were expected to attend.
- Reception staff reported that they received annual basic life support training.

Multidisciplinary working

- There were examples of multi-disciplinary working both within the A&E and within the wider hospital. For example the advanced nurse practitioners worked alongside the medical staff and were included on their duty rota.
- Notable was the integrated working between the A&E and EAU. This particularly benefited older patients with sometimes complex medical needs for whom the fluidity of the patient pathway really improved their experience. The acute physicians provided an 'in-reach' service to A&E where patients could be quickly assessed and treated by appropriate specialties. When admitted older people were usually cared for in the complex older person environment (COPE). This was an area in EAU geared to care for frail older people. Staff told us that patients admitted there were more likely to go home quickly and avoid a longer admission.
- The department had established links with the local primary care service through the Salford Integrated Record System (SIRS) so that they could access patient's GP records. This provided valuable patient information quickly for clinicians on the department.
- Specialist paediatric medical and nursing staff from the PANDA unit worked on A&E when a child was admitted to the resuscitation area. We saw this in practice during the inspection when a child was admitted to the dedicated paediatric bay in A&E's resuscitation area.
- Staff reported excellent access to occupational therapy, physiotherapy and the early discharge teams.
- There was access to a community psychiatric nurse service 24 hours per day, seven days a week with a one hour response time for A&E. There was also access to an alcohol and substance misuse liaison team.
- There was evidence of wider working with Salford CCG and Salford council to consider ways of improving A&E performance.

Seven-day services

- The A&E department provided a seven day a week service to the local population.
- It was staffed accordingly with adequate numbers of suitably skilled nursing and medical staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The nursing staff had an awareness of the Mental Capacity Act 2005 (MCA) and had an understanding of what deprivation of liberty meant.

Urgent and emergency services

- Junior doctors also had awareness but stated that they had not had any formal training in the subject area of deprivation of liberty safeguards.
- Staff produced for us a copy of a flowchart for managing deprivation of liberty safeguards.
- We also saw that the EPR had a section to be completed which prompted staff to ask themselves if they had any reason to think that a patient may not have capacity. If they ticked the field to say 'yes' then a series of further fields emerged to assess mental capacity. In such an instance the EPR also 1) sent an email notification to the hospital safeguarding team and 2) prompted the staff to consider whether a best interest decision was appropriate.
- None of the staff that we spoke with could recall a deprivation of liberty referral being raised for any patients in the A&E.

Are urgent and emergency services caring?

Outstanding ☆

Overall we found that the service was providing outstanding care in a compassionate manner. Staff were observed to "Go the extra mile" in order to meet the emotional and psychological needs of patients.

We observed staff treating patients and relatives with respect. Feedback from patients, relatives and carers was consistently positive; patients told us that the staff on A&E kept them well informed and involved in the decisions about their care and treatment. Care was person-centred; staff were observed to provide care which maintained the dignity of patients.

This view was reflected in the consistently high performance in the Friends and Family Test, the trust's own Picker surveys and the national A&E survey.

Compassionate care

- Throughout the inspection we saw all staff treating people with dignity, respect and courtesy. For example, the curtained cubicles were labelled on the outside reminding staff to close them and so help to preserve the patient's dignity.
- Salford Royal's Patient, Family and Carers Experience strategy had developed six 'always events', which set the standards for what all patients, families and carers should expect to receive all of the time be it in A&E or in a clinic or at home. It was made clear to staff that it was their responsibility to ensure that all patients received these standards. Staff told us that the A&E department was heavily involved in this collaborative which was part of the trust's quality improvement strategy.
- We received comments from patients during the inspection that praised the way in which care was delivered in the department. For example one patient told us that they lived outside of Salford but that they would 'Travel to Salford A&E if I need the service because the staff go above and beyond'.
- In the 2014 A&E survey the trust performed better than other trusts in the following areas:-
  - If you needed attention, were you able to get a member of medical or nursing staff to help you?
  - While you were in A&E did a doctor or nurse explain your condition or treatment in a way that you could understand?
  - Did you have confidence and trust in the doctors and nurses examining and treating you?
  - If your family or someone else close to you wanted to talk to a doctor, did they have an opportunity to do so?
  - If you had any anxieties or fears about your condition or treatment did a nurse or doctor discuss them with you?
  - If you were feeling distressed while you were in the A&E
- The trust can be seen at times to be performing better than the England average for the Friends and Family Test (FFT), which is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family

Test highlights both good and poor patient experience. For example, the area of questioning for: were you given enough privacy when being examined or treated is better than the England average.

- FFT performance across a four month period between October 2014 and January 2015 was consistently better than the national average for both response times and outcomes. The response rate for FFT was 23% against an England average of 20%. 92% recommend the service against an England average of 88% for January 2015.

Understanding and involvement of patients and those close to them

- The trust introduced volunteers into the department to ensure patients received refreshments; volunteers provided a variety of soups, biscuits and sandwiches for patients in the ED. The introduction of volunteers in the department had also enhanced the patient experience as they were ensuring that patients were getting drinks when appropriate and could also spend some time talking to patients who may be unaccompanied.
- The department had instigated a member of staff to take the lead on patient engagement initiatives.

Emotional support

- We were told that the staff would take photos or provide mementos such as a lock of hair or hand prints, if appropriate.
- We heard examples from staff of very personal and compassionate end of life care. One example involved the care of a patient who was dying and requested a preferred drink rather than the hospital mouthwash to assist with their oral hygiene and this was facilitated.

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

Good

There were many areas of innovative practice being undertaken in response to the needs of the local population. The trust had identified issues with patient flow and had engaged with a range of external stakeholders including Salford City Council and Salford Clinical Commissioning Group to develop a recovery strategy to address the issues. The trust considered the needs of the local population to ensure the services that they delivered were suitable and sufficiently flexible to meet those needs of people.

Initiatives were developed which addressed all aspects of patient flow both pre-hospital, within the hospital and for the discharge of patients back into the community.

In September 2014, the department started to implement many of the initiatives from their improvement plan, which amongst others, involved significant changes to the physical layout of the A&E, physically separating out the minor injuries area and expanding capacity in majors. This building work was completed in six weeks so as to reduce the impact on the local population and was demonstrable of the commitment of the workforce to provide individualised and person centred care.

Service planning and delivery to meet the needs of local people

- The number of patients attending Salford Royal's A&E department in the current year, 2014/2015 was 75,827 up to and including the week ending 18 January 2015. The average waiting time target for the same period was 94.05% (the target is 95%). For the year 2013/2014 the annual attendances at A&E were 88,264 with an average four hour waiting time target of 95.87%.
- In order to try and address the issues of patient flow, not just through A&E but the wider health economy the hospital developed an improvement plan in conjunction with other strategic partners such as the local council and clinical commissioning groups. This involved a major refurbishment of the existing department footprint which included a separate nurse led minor treatment area. This allowed for expansion of the major treatment facility to 22 patient areas, which was designed to include an increase in the number of individual cubicles to enhance the privacy and dignity of patients. In addition there were eight patient bays in the resuscitation area, including one bay designed and equipped especially for the resuscitation of children.

Urgent and emergency services

- In order to help meet the increasing demand on the department a range of additional initiatives had also been introduced to improve the patient's experience. These included:-
  - Development of the 'Emergency Village' which provided an effective service especially for older people who attended A&E. It enabled an early review by clinicians specialised in the care of older people with complex needs with an option for admission if indicated to the adjacent emergency assessment unit in a section known as the 'COPE' or complex older person's environment.
  - Dedicated deflector role and see and treat model in minors for adults and paediatrics.
  - Dedicated urgent appointment slots in primary care for patients deflected from A&E.
  - Four daily executive led capacity meetings with mandatory attendance by all specialities to review both unscheduled and scheduled capacity and demand together with staffing levels across the trust seven days per week.
  - Electronic patient tracking system used by staff to monitor the flow of patients through the department
  - Radiology co-located with A&E. Dedicated diagnostics at triage and priority access for all radiology/pathology requests.
  - Traffic light alert system on trust intranet to advise all employees of daily situation in A&E, critical care and overall bed capacity.

Meeting people's individual needs

- An information leaflet was available and given to patients on arrival with information about the emergency department and why patients were waiting. The department was aware that they needed to develop alternative formats to support individuals with communication needs and we were told that they were engaging with people with sensory disabilities and were looking to develop a DVD version of the leaflet with audio.
- The information leaflet was in full colour and included a useful section on the different uniforms worn by the staff so that patients and carers could determine who was who.
- Translation services were available.
- We saw that training was given to nursing staff on managing those people living with dementia and learning disabilities and the specific additional care that they may need.
- As part of the hospital's discharge, aftercare and re-enablement service we saw that Age UK Salford provided a support service for Salford residents aged 55+ who had attended A&E. They received a daily data set from the trust and duly contacted people who had been discharged from A&E to ensure that they were coping with daily activities.
- With the aim of better understanding the patient experience in A&E, the trust governors had led on an engagement plan, which recognised areas of the A&E experience that could be improved and subsequently developed a time limited action plan to achieve progress. The required actions for improvement identified in the plan had started in December 2014 and were due to be completed by May 2015. Examples from the improvement plan included that the initial engagement work had identified that the external signage to the department was poor and unhelpful; new signs had been purchased and one already erected. A further example related to the customer service provided by the reception staff and the project had identified that the A&E reception staff would benefit from customer service training with special attention given to the interaction required with people who had sensory impairments. The senior A&E team were tasked with facilitating and providing this training by April 2015.
- A relative's room was available in a quiet part of the department with an adjoining viewing room, which had been set up to look less clinical than the usual examination or assessment rooms.

Access and flow

- Waiting times were an on-going problem. The department was trying to communicate the waiting times through an electronic board in the main waiting area and the triage nurse informed patients of the wait

on their arrival to the department. The recently opened nurse led minors unit had improved the waiting times for patients attending the department with minor injuries. We were told that there were plans to audit the effectiveness of the electronic board by securing patient feedback.

- The trust was performing better than the England average with regards to handover of patient care from the ambulance crew to the A&E department, and the number of hand-overs delayed over 30 minutes in the winter period compared to all trusts is much better than the England average.
- The trust was performing better than the England average for the percentage of emergency admissions through the A&E department waiting 4–12 hours between the decision to admit and being admitted. In January 2014 the trust was performing at 3%, the England average being 5.5%.
- The percentage of patients that left the department before being seen was worse than the England average from January 2013 to May 2014. However, we were told that patients who did leave the A&E before being seen were followed up with a telephone call to try and establish that they were safe. We noted that since September 2014, the number of patients leaving the department without being seen was 3.2% which was in line with CEM standards of less than 5% of patients leaving the department without being seen.
- The total time in A&E average per patient was worse than the England average from January 2013 to May 2014.
- In the summary for September 2014, 95% of patients waited under 17 minutes from arrival to initial assessment. On average, patients waited 56 minutes from arrival to treatment. 95% of patients waited under 239 minutes from arrival to departure. 95% of patients not requiring admission to hospital waited under 234 minutes from arrival to departure and 95% of patients who needed admission to hospital waited under 300 minutes from arrival to departure of the A&E department.
- The College of Emergency Medicine recommends that the rate of unplanned re-admittance within seven days for A&E should be between 1 and 5%. The national average for England is around 7%. The trust had consistently performed around the same as the national average against unplanned re-admittance since January 2013. Their rate ranges from 7% to 7.5% reaching 8% on occasions.
- In addition to the triage role the A&E had also developed a 'deflector' role. This was undertaken by suitably qualified nurses such as emergency and advanced nurse practitioners and emergency care practitioners who would see patients that had been triaged as not requiring admission to the A&E department and who might be more appropriately managed by primary care services or by self-management. For example, we saw an occasion where a patient attended the A&E with back pain that they had been experiencing for a period of days. It was assessed that this patient could be more appropriately managed by attending their GP; the department had established an arrangement with all local GPs where they held two appointments each day into which they could directly book 'deflected' patients. In this specific case the patient was given prompt analgesia and an appointment with their GP that afternoon. The patient was satisfied with this outcome. We were told by staff that no children under the age of 12 months were ever 'deflected'.

Learning from complaints and concerns

- The A&E had a rigorous complaints answering process which addressed both formal and informal complaints which were raised via the Patient Advocacy and Liaison Service (PALS). Formal complaints involved the Assistant Director of Nursing checking and assessing the responses carried out by the department matron. With informal (PALS) complaints the corporate matron (or lead nurse/departmental matron in corporate matron's absence) discussed with the concerned patient/family as soon as possible after receiving the call with the aim of rapid resolution of the problem. All complaints were answered fully with an assessment of root causes made.
- We saw examples of response letters to complainants and these included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
- Learning opportunities were always taken, with both feedback to individual staff and system changes made

as appropriate and required. For example, following a patient fall from a trolley, practice was changed to introduce intentional rounding, (this involves nurses carrying out regular checks on patients to ensure that their fundamental needs are being met) and the use of low rise trolleys.

- The department was also involved in a trust wide falls collaborative group. Lessons learnt from complaints were discussed at the senior nursing team and full nursing team meetings. They were also taken to the department governance meeting. The issues were debated and staff challenged to find solutions. Learning from complaints or incidents was shared with staff via email and the daily safety huddles.
- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS).
- There is a page on the hospital's website that encourages patients to raise their concerns, if at any time if they believe their care has not been safe, clean or personal. There are a number of routes by which this can be facilitated including the use of a 'help' phone. These were found around the hospital site; although there was not one in A&E. Via this phone patients were able to contact a senior member of the clinical team who investigated their concerns within the hour.

Are urgent and emergency services well-led?

Outstanding ☆

Overall we found that the A&E service was outstandingly well led. This was apparent at divisional and especially departmental level.

All staff were clearly engaged with the department's vision and strategy. There was a culture where change was embraced and everyone was on board with the quality initiatives being tested. There was a real focus on patient experience and this was driven by the department's leadership both clinical and managerial.

All staff were proud of working for the department. It was evident that staff worked well together as a team. Clear governance structures were in place designed to enhance patient outcomes.

Vision and strategy for this service

- It was evident from talking to all staff that there was a pace of change in the department, reflected by the number of service reconfigurations, all geared to improving the experience of patients and their journey. This pace of change was on-going with plans to develop the service further. For example, the service expanded the number of resuscitation bays in line with the department's status as a major trauma centre for Greater Manchester.
- Staff felt engaged and involved in the development of the A&E service.
- The trust had published in its 2014/2015 quality accounts a number of trust wide quality initiatives which the A&E had also bought into. For example, one of the trust's key quality priorities was in the early detection and treatment of sepsis (sepsis arises when the body's response to an infection damages its own tissues and organs and can lead to shock and organ failure). In response to this, and considering the outcomes of the CEM audit into Sepsis, the department had appointed a nurse as a sepsis lead to drive through an educational programme to improve the early detection and treatment of sepsis.
- Another key priority was assuring patients and relatives that the staffing levels and skill mix were safe.

Governance, risk management and quality measurement

- The introduction of the Nursing Assessment and Accreditation System (NAAS) had been successful in measuring the quality of nursing care being delivered. It supported nurses in their practice, identifying what worked well and also where improvements were needed. The trust had set a goal of all wards and departments achieving their Safe, Clean and Personal Status Every Time (SCAPE) by 2015. This could only be realised once the department had, as a minimum, achieved green status in the NAAS for 24 months.

Urgent and emergency services

- A robust governance system was in place with the production of detailed information about the department's performance which was discussed at regular governance meetings and used to demonstrate effectiveness.
- The senior staff we spoke with were clear about the challenges the department faced and they were all committed to improving the patients' journey and experience.
- Where the department had performed poorly in national audits, the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes. For example, the management of pain relief in patients with a fractured neck of femur.
- A departmental risk register was available and was continually under review to ensure that it reflected the current risks relevant to the operational effectiveness of the department. A total of 35 risks were recorded on the register at the time of our inspection. Each risk was rated red, amber of green (RAG Rated), dependent on the severity. 28 risks were graded as "Moderate", 5 "Serious" and 2 "Significant". Each risk had an assigned executive lead and descriptions of key controls to help mitigate risks. Assurances were embedded into the risk register in order that effective monitoring took place; there was escalation of risks to the board where necessary.

Leadership and Culture of the service

- The A&E service had a clear management structure both at divisional and departmental level.
- Within the past three years, the pace of change had been significant. The leadership and staff on the department had opened a new A&E, and then reconfigured it when it became clear further changes were needed. During this time they had also secured major trauma centre status, expanded the stroke service, gone paperless and managed to recruit 50% more consultant staff. This speaks volumes for the commitment of the whole team in providing a better service for their patients.
- There was a high level of clinical skill amongst the department's senior nurses, who, led by a matron and lead nurse were able to support and lead their teams.
- In the 2013 NHS staff survey 45% of staff felt that there was good communication between senior management and staff. This was generally much higher than other acute trusts and above the average score of 32%.
- From our observations and discussions with staff it was apparent that there had been changes to the way the department was configured recently in accordance with the improvement plan. Not least of which was the introduction of the EPR system. We found universal acceptance and understanding of the need for the changes which were being made to improve the quality of the service to patients.
- There was a 'can do' attitude conveyed by all the staff that we spoke with.

Public and staff engagement

- In the 2013 NHS staff survey 86% of staff who responded stated that they were satisfied with the quality of the work and patient care they were able to deliver.
- In the 2013 NHS staff survey 76% of staff stated that they felt able to contribute to improvements at work. This was high than most other acute trusts and reflects the fact that staff are engaged with and able to contribute to changes in practice development.

Innovation, improvement and sustainability

- There was clear evidence that the development of the 'emergency village' with its integrated care pathway approach, including medical in-reach, continued to deliver improved outcomes for people.

Medical care (including older people's care)

Safe	Outstanding ☆
Effective	Good ●
Caring	Good ●
Responsive	Outstanding ☆
Well-led	Outstanding ☆
Overall	**Outstanding** ☆

Information about the service

Salford Royal NHS Foundation Trust (SRFT) provides gerontology, cardiology, gastroenterology, respiratory medicine, neurology, nephrology, diabetic, and stroke and specialist rehabilitation services across 16 wards within the medical division. There is no defined 'Medical Division' at SRFT – the medical specialities are split between two main divisions – Division of Neurosciences and Renal Services and Salford Health Care. However for consistency of reporting, this report uses the term Medical Division as an umbrella term for all of the medical specialities providing care at SRFT.

We inspected the medical HDU, acute stroke unit, stroke rehab unit, elderly care wards (L8, L5,L4,), general and speciality medicine wards(B3, C2, H2,H3,L6) gastroenterology ward (L2),coronary care unit (HCU), acute neurology unit and ward (C1) and the inpatient discharge lounge. We also visited patients who were being looked after by medical consultants, but due to lack of capacity on the medical wards were accommodated on surgical wards.

We spoke with about 24 patients including their family members, 54 staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and consultants other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

We found that patients were protected from avoidable harm and abuse within the medical division at SRFT. Overall we rated this service as outstanding for this domain as the concept of 'safe' was clearly so firmly and consistently embedded throughout the division.

Standards of hand washing and cleanliness were consistently high and regularly audited. The concept of reporting of incidents was embedded amongst nursing and allied health care professionals. When this system was not utilised there were other channels by which concerns could and were raised. We found that the trust took a proactive stance towards resolving any issues which had the potential to impact on patient safety and staff were clearly attuned to the expectation that potential safety concerns should be raised immediately and without fear of retribution. Quality improvement strategies were developed and outcomes were closely monitored to ensure patients received harm free care.

Medical care services at SRFT were rated as good in terms of delivering effective care. Use of NICE guidance was widespread and national and local guidelines were easily accessible on the trust intranet. All national audits relevant to the medical division had been contributed to and the trust were able to provide evidence of changes made in response to the feedback received. It was clear that clinical audit was seen and used as an effective improvement tool.

Medical care (including older people's care)

In line with the rest of the trust, concerns were found during our inspection regarding the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS). The trust had already taken steps to address this at the time of our unannounced inspection.

Overall we judged medical care services to be caring. Patients received compassionate care and were treated with dignity and respect and their privacy was preserved. Patients and relative we spoke with said they felt involved in their care and were given adequate information about their care and treatment. Feedback from patients and their relatives told us that they felt psychologically supported by hospital staff. Patients felt very happy about how they were looked after and complimented the staff looking after them.

The trust has a higher response rate to the friends and family test than the England average. The scores have become higher this year than last. This is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family Test highlights both good and poor patient experience.

Medical care provided at SRFT was responsive to patient's needs. The acute medical unit was well established and led the way in embracing the national four hour target as 'everyone's business' and not just the responsibility of the A&E department. Extensive work had been undertaken to reduce avoidable admissions and improve early discharges. Whilst out of hours transfers still occurred, these were kept to a minimum and reported to senior team members. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result.

Medical care services at SRFT were exceptionally well led. Clear accountable governance structures existed and risks were identified early and owned by individuals who were appropriately held to account. The culture within the division was one of openness and honesty. The trust wide objectives (Safe, Clean and Personal) were well known by all levels of staff and individual divisions had aligned their priorities to the wider goals of the trust. Staff development was seen as a key driver of improvement and there was evidence of widespread investment in staff encouraging loyalty and engagement at all levels. This meant that staff were empowered to identify areas within their own service to improve.

Medical care (including older people's care)

Are medical care services safe?

Outstanding ☆

We found that patients were protected from avoidable harm and abuse within the medical division at SRFT. Overall we rated this service as outstanding for this domain as the concept of 'safe' was clearly so firmly and consistently embedded throughout the division.

Standards of hand washing and cleanliness were consistently high and regularly audited. The concept of reporting of incidents was embedded amongst nursing and allied health care professionals. When this system was not utilised there were other channels by which concerns could and were raised. We found that the trust took a proactive stance towards resolving any issues which had the potential to impact on patient safety and staff were clearly attuned to the expectation that potential safety concerns should be raised immediately and without fear of retribution. Quality improvement strategies were developed and outcomes were closely monitored to ensure patients received harm free care.

Incidents

- 57 falls had been reported during the period July 2013 to July 2014.We saw that each of the wards we visited had information on display which reported the number of days since a patient had last fallen on the ward.
- There were clear strategies for minimising the risk of patient falls on the medical care wards. We saw that where patients had been assessed as a possible clinical risk, a red dot was displayed on the patient's bedside board.
- Staff told us that they reported incidents through a computer software package that enabled incidents to be submitted from wards and departments. All staff we spoke with across medical care services at SRFT were aware that incidents should be reported and were able to use the system. That said, the junior doctors we spoke with said that they did not always report incidents as they would use alternative avenues to raise concerns about patient care, for example through the Quality Improvement forums.
- A ward matron told us that all incidents were investigated and that they communicated any learning from these through ward meetings and in the staff communication folder. We saw that the communications folder was accessible to staff with action plans developed and any learning was discussed with the staff.
- On two wards we observed the lead nurse sharing information on incidents. Staff we spoke with confirmed that incidents were discussed and learnt from and they were also able to access the learning from incidents via the staff intranet.
- We looked at a recent incident on a ward where controlled drugs had not been fully accounted for. We saw that the incident had been fully investigated with involvement and support from the human resources department and the police. An action plan had been put in place to prevent a recurrence, demonstrating that there had been learning from the incident.
- The ward matron on L6 advised us that records of patients who died were reviewed by a named consultant.
- We reviewed data which demonstrated that directorate leads reviewed the deaths of each patient who had died within the hospital. Initial reviews of deaths were carried out to identify any immediate concerns or where changes in practice could be instigated. We noted that a mortality review tool had been developed which had been designed to enhance the mortality review process with an aim to have an initial review of all deaths within 24 hours of occurrence.
- In depth monthly mortality and morbidity meetings were held monthly where all deaths were reviewed using internationally recognised methodology. On a 6 monthly basis each directorate reported to the Clinical Effectiveness Committee, including what learning points had been identified. These were then shared across the divisions and any shared learning disseminated back down at local level by the clinical directors at clinical governance meetings.

Safety thermometer

- Data was collected on a single day each month on the medical wards to indicate performance in key areas of safety (falls, pressure ulcers, venous thrombolytic

embolus (VTE) and catheter associated urinary tract infections).Safety Thermometer scores for 'harm free' care ranged between 93% and 97% between November 2013 and November 2014.

- The safety thermometer had shown a high number of pressure ulcers recorded in medicine; however the rate of new pressure ulcers was very low, indicating that the vast majority of the ulcers had been sustained prior to patients arriving at the trust. Following the implementation of quality improvement initiatives to address the occurrence of pressure ulcers, two wards had seen a reduction of hospital acquired pressure ulcers from 7 and 10 between February 2013 and February 2014 to zero ulcers between February 2014 and February 2015.
- We were told that the trust were also undertaking additional work to identify the frequency with which patients were catheterised to determine whether inappropriate catheterisation was taking place; this initiative was supported through the use of trust wide audits as well as junior doctors being required to conduct patient experience audits to help them understand the experience of having a catheter in situ.

Cleanliness, infection control and hygiene

- We observed that the environment was visibly clean and well maintained.
- All wards had hand basins at their entrances (or just inside the ward).There were large signs encouraging members of the public and staff to wash their hands prior to entering the wards. We witnessed people who did not wash their hands being challenged by all levels of staff (from receptionists to consultants).Junior Doctors corroborated that this was 'business as usual' and since joining the trust washing their hands prior to entering the ward had become routine for them all.
- Regular cleaning audits were carried out. In the medical division compliance rates for the three months October to December 2014 for wards HCU, H2, L2, L3, L4, L5, L6 and L8 was 97%
- We looked at the results of the patient–led assessments of the care environment (PLACE).SRFT achieved a cleanliness score of 99.46% in 2014 against the national average of 97.25%.
- At all entrances to the wards there were quality and information boards which were updated daily. This gave details of the number of days since the ward had been methicillin resistant Staphylococcus aureus (MRSA) and C.diff free.
- We observed that where there were concerns that a patient may have developed a C.diff infection, they had been isolated in a single room and staff were taking appropriate precautions through the use of plastic aprons and disposable gloves.
- We saw that there were ample supplies of personal protective equipment such as disposable gloves and plastic aprons and we observed staff using them as necessary.
- Hand hygiene was audited monthly. In medical services compliance rates for the three months October to December 2014 for the following wards, HCU, H2, L2, L3, L4, L5,L6 and L8 was 99.98%.Adequate hand washing and hand sanitisers were available in clinical areas. We observed staff decontaminating their hands following the World Health Organisation's "five moments for hand hygiene" guidance. The Trusts hand hygiene policy had been reviewed in January 2014.
- We saw that equipment shared between patients was labelled with a distinctive green label indicating that it had been decontaminated and was ready for use. Staff we spoke with understood this labelling system.
- The trust reported one case of MRSA bacteraemia in the past year. In response, a full root cause analysis had been undertaken and concluded that there had been no failure in care contributing to the infection.

Environment and equipment

- Health and safety and fire safety training was part of the mandatory training programme that staff were required to attend.100% of staff working within the medical division had attended training for health and safety and fire safety. We looked at the results of the patient–led assessments of the care environment (PLACE).SRFT achieved a score of 98.12% for condition, appearance and maintenance of equipment against a national average of 91.97% in 2014.
- We observed that there was sufficient moving and handling equipment to enable patients to be cared for safely.

Medical care (including older people's care)

- We saw resuscitation equipment was readily available on each ward. There were daily checks of resuscitation equipment on all the medical wards and these checks were documented.
- We saw that all portable electronic equipment had been tested for electrical safety within the last twelve months and had testing appliance labels attached.
- We saw that SRFT had been awarded a food hygiene rating of five across all its patient and ward kitchens in December 2013.

Medicines

- We observed medicines being administered by qualified nursing staff.
- We saw that medication was stored correctly and that controlled drugs were checked daily.
- The wards used computer based systems to record when medication had been administered. Ward matrons told us that this enabled them to monitor when drug rounds were late and helped reduced medication errors.
- We saw that medications held on the wards were securely stored. Only staff who had undergone training to access the medication and use the electronic dispenser could access medications.
- Pharmacy technicians undertook regular stock reconciliations for medications on the ward and ensured that appropriate medicines were available for patients.
- Patient medication records from past admissions as well as GP prescriptions were easily accessible, thus reducing the likelihood of alterations to medications being missed. This also meant if the patient was unaware of what medication they were on when they were admitted, this could be accessed out of hours, reducing delays in patients receiving their correct medication.

Records

- Throughout the trust, including the medical division, electronic patient records (EPR) was in place. The EPR was fully integrated between all health care professionals resulting in all professionals involved in a patient's care being able to access their full record.
- The electronic patient records were updated in real time with the dates, times and the designation of the person documenting.
- Previous admissions and GP attendances could also be accessed meaning that staff were able to see previous care plans for patients without any delay in waiting for old sets of notes. This also meant that GPs did not have to be contacted directly to identify whether a patient had been to see their GP recently about a similar complaint. Some staff told us that they were waiting for their access code and as such were not yet able to access the system. In addition, staff told us that the care support workers were only recently able to access the EPR.
- Some staff conceded that when records had become electronic that 'it took a bit of getting used to'. That said, we were unable to find any member of staff who, given the choice would want to go back to patient records.
- We looked at patient records and they reflected the care and treatment patients received. However we found that the care planning was generic and the majority of records we looked at were not personalised.
- We saw that patient passports had been completed by the patient and or relative but the information was not always incorporated within the care plans.
- The nurses completed risk assessments electronically. The pressure ulcer risk assessments, nutrition risk assessments, moving and handling risk assessments and falls risk assessments which we looked at were fully completed and reviewed on a weekly basis.
- Doctors assessed patient venous thromboembolism (VTE) risk electronically. If this had not been completed an alert was automatically generated prompting staff of the need for this to be completed.
- The medical division used paper international rounding documentation which was completed regularly and checked by a nurse. However, we found examples where food intake was meant to be monitored but was not always completed appropriately.

Safeguarding

- Safeguarding policies and procedures were in place and staff were aware of these.
- Safeguarding adults and children formed part of the mandatory training programme for staff at Salford Royal. We saw that across the medical care services 100% of staff had completed training in safeguarding children and adults.

Medical care (including older people's care)

- Some staff we spoke with were not aware of who the lead for safeguarding was in the trust. However staff were aware of their responsibilities to report potential abuse and knew how to report via the phone or through completing an appropriate form.
- We observed a member of the hospitals safeguarding team working on a ward with input from nursing staff and a social worker.

Mandatory training

- Mandatory training was 96% or higher across the medical care wards. The target across the hospital was 95%.
- The ward matrons told us that it was the ward staffs responsibility to book their mandatory training which they could do on-line. They told us they would monitor attendance to ensure that training had been completed and kept up to date with their training.
- Staff informed us that mandatory training requirements differed depending on the clinical area they worked. For example, staff working on care of the elderly wards were required to undertake training in relation to the management of patients who lived with dementia.

Assessing and responding to patient risk

- The wards used the Salford National Early Warning Score and medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected.
- Patient observations were measured at the bedside by nurses or health care assistants and entered onto hand held electronic devices. These automatically calculated individual early warning scores for the patients. Early warning scores of five or above immediately triggered an alert.
- There is an established audit programme which requires individual wards to audit the accuracy of the completion of the early warning scores. This is complemented by monthly unannounced 'spot check' audits undertaken by the resuscitation team.Every ward receives a formal report of these and poor performance results in an action plan and rapid re-audit.
- Other health care practitioners could access the scores via the EPR from any computer within the trust. Trends could be easily identified and acted upon if required and historical scores could be accessed for comparison. The Salford National Early Warning scoring tool was fully integrated into the trust-wide 'iBleep' system which meant that senior nursing and medical staff, including those who supported the 'Hospital@Night' Team could be alerted to patients who may be clinically deteriorating.
- On each ward we saw there was a resuscitation allocations board which detailed nursing staff responsibilities on each shift.This meant that there were named nurses responsible for the 'Airway, Breathing and Circulation' part of a resuscitation event.Staff told us that this worked well as staff knew what task they were responsible for in the event that the resuscitation trolley had to be deployed.
- At the start of each day and night shift the on-call teams met and allocated similar roles. This meant that in the event of an emergency, individual responsibilities were clear.
- Ward staff told us that 'mock arrests' were undertaken in order to refresh the doctors and nurses emergency skills. This also allowed for gaps in learning to be identified and acted upon. This was seen as particularly important as the number of cardiac arrests fell within the trust meaning that teams could go long periods of time without being called to an emergency situation.
- Staff told us that any patient concerns were discussed at twice daily safety huddles on the wards which all staff attended. We observed several of these huddles and found them to be comprehensive, well-structured and adhered to. Although there were certain subjects that it was expected would be covered on all wards (such as patients with the same name, or patients who had active DNACPR orders in place) the huddle could be personalised to the specific ward. According to nursing staff we spoke to this resulted in increased ownership of the huddle rather than it just being a 'top down mantra'

Nursing staffing

- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'.
- Ward matrons were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased.

Medical care (including older people's care)

- The trust utilised the Association of UK University Hospitals Safer Nursing Care tool (AUKUH) to determine ward acuity and staffing levels; wards were staffed with a 1:8 nurse to patient ratio with an additional supervisory shift co-ordinator and supernumery ward manager. Staffing levels were tracked at 6 points throughout the day to ensure that safe staffing levels were maintained.
- A review of "Safer staffing" records demonstrated that where there were deficits in the number of registered nurses available to work a particular shift, the number of care support workers were increased to ensure that the needs of patients could be met. For example, we noted that in December 2014, on ward L5, the number of registered nurses available over a period of one month was 89.6%; the number of care support workers was noted to be 117.6% which was significantly higher than the budgeted establishment.
- We saw that there was a daily handover with the whole multi-disciplinary team in a form of a board round and observed one in progress with each of the patients on the ward discussed. Nursing staff told us that these were a useful forum for ensuring they had access to all the relevant information to provide care.
- We saw that there were arrangements for nursing staff to handover the care of patients between shifts. Staff carried printed handover sheets. We looked at these sheets and found that they contained relevant information on a specific patient's needs. In addition, the safety huddles were used to handover pertinent information regarding patient care.
- Some wards we were advised that there were some nursing vacancies but recruitment was in process and that last year the Trust over recruited to some nursing posts. Ward matrons informed us that they were involved in recruiting their own staff to ensure that wards had good mix of skills and experience
- We saw that where wards used temporary staff there was evidence that staff had been inducted on to the ward and the check list had been completed and signed off by ward staff.

Medical staffing

- Salford Royal has a higher number of consultants (43%) working at the hospital than compared to the England average of 33%.
- There are no nationally agreed standards for the number of junior doctors required to cover medical patients overnight. That said, none of the junior doctors we spoke with raised any concerns with the on call cover arrangements, with several commentating that 'nights are busy but not unmanageable'.

Major incident awareness and training

- Staff we spoke to were aware of the procedure for managing major incidents or an event that impacted on business continuity.Staff we spoke with were aware that the trust had major incident and business continuity plans and knew where they could find guidance if needed.
- Emergency plans and evacuation procedures were in place and staff were trained in how to respond.
- As a result of winter pressures additional beds had been opened on L7. The ward matron informed us that to support the additional 8 beds, their staffing levels had been increased to ensure the needs of patients could be met.

Are medical care services effective?

Good

Medical care services at SRFT were rated as good in terms of delivering effective care. Use of NICE guidance was widespread and national and local guidelines were easily accessible on the trust intranet. All national audits relevant to the medical division had been contributed to and the trust were able to provide evidence of changes made in response to the feedback received. It was clear that clinical audit was seen and used as an effective improvement tool.

In line with the rest of the trust concerns were found during our inspection regarding the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS). The trust had already taken steps to address this at the time of our unannounced inspection.

Evidence-based care and treatment

- All new national guidance issued is discussed at and reported to the Clinical Audit Committee which meets monthly. If the guidance is deemed relevant to the medical division a named person is identified to ensure

that the guidance is disseminated in accordance with the trust policy. An actioned response with evidence available is expected within three months of the Audit Committee meeting.

- The clinical audit committee was able to assure itself that individual medical specialities were compliant with over 70% of national guidance in place.
- Trust and National guidelines could be accessed using the trust intranet. Staff reported that they were easy to access and use.We saw that a wide range of guidelines were available across most of the medical specialities.

Pain relief

- We observed that pain relief was discussed at ward rounds with nurses and doctors monitoring the pain levels of patients and recording the information. In addition, patients were specifically asked about their pain as part of the intentional rounding.
- If pain was difficult to manage, ward staff could contact the Specialist Pain team for their input. This multidisciplinary team included specialist nurses, consultants with an interest in pain management, physiotherapists and health psychologists.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical care wards. The wards nutrition boards were updated daily by the house keepers following the safety huddles where patients' diets and Speech and Language Therapy (SALT) assessments were discussed.
- We observed that fluid balance charts were used to monitor patients' hydration status.
- The 'Malnutrition Universal Screening Tool' (MUST) was used in all the wards. Patients who were assessed to be nutritionally at risk were referred to a dietician.
- We saw that all patients had access to drinks which were within their reach. Staff checked that regular drinks were taken where required.
- Dietary supplements were given to people when prescribed
- Food that met peoples special and cultural and religious needs was available
- A red tray system was used on all the medical wards to identify patients who needed help with eating and drinking. Housekeepers ensured that all the patients were given right type of meals as advised by dieticians; for example pureed or soft diet.
- We visited three medical care wards at mealtime. We observed that meal times were calm and coordinated with staff allocated different tasks and bays. We saw that patients in the bays received their meals at the same time to make it more of a social occasion and we observed nursing staff assisting patients who needed support to eat.
- On some of the elderly care wards we saw that there were separate dining areas where patients could eat together if they chose too. We observed lunch time on four different wards and saw that these facilities were well received by patients and regularly used.

Patient outcomes

- According to the Sentinel Stroke National Audit Project (SSNAP), the trust achieved a 'B' grade (range A (best) to E (worst) between July and September 2014 (the latest data available at the time of our inspection. It is acknowledged nationally that the criteria for the grading is very stringent – at present there are very few trusts that have achieved Grade 'A'. What is striking about this is that the department has improved from a grade 'D' over a relatively short period of time demonstrating a desire to improve its service in response to the audit.
- The trust submitted data to the National Diabetes Inpatient Audit (NaDIA) which audits diabetic inpatient care in England and Wales, by capturing a 'snapshot' of measures of care during a random week. The results from 2014 are not yet available, but for 2013 the trust were in the lowest quartile for medication and management errors. It was also in the highest quartile for the percentage of patients receiving a foot assessment and having been seen by the multidisciplinary foot diabetic team within 24 hours.
- As well as the national mandatory audits the trust was able to provide evidence of involvement in multiple local audits over and above the NCAPOP program, to include the recommendations in the Quality Accounts from HQIP.

- 'Division of Medicine Audit Registry' was updated regularly and reported to the trust wide clinical audit committee.
- The standardised relative risk of readmission for elective cases during 2013/2014 was better (lower) than the national average (94 vs 100). The risk of readmission for non-elective cases was worse (higher) than the national average (111 vs 100).
- The trust performed better than, or similar to the England average in 5 out of 7 indicators in the 2012/2013 Heart Failure Audit (discharge). However, the trust performed worse than the England average in three of four indicators in the 2012/2013 Heart Failure Audit for inpatient care.
- Data from the 2012/2013 Myocardial Ischaemia National Audit Project (MINAP) demonstrated that 64% of patients presenting with a non ST elevated myocardial infarction (nSTEMI) were admitted to a cardiac ward; this was better than the national average of 53%.
- 99.5% of nSTEMI patients were referred for or had an angiography either during their inpatient stay or following discharge; this was better than the national average of 75.6%.

Competent staff

- Staff told us they had regular annual appraisals and attended appraisal training. Staff told us that they found the new contribution framework introduced in April 2014 to have a greater emphasis on their development and their contribution to the objectives of the trust.
- Staff were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example staff on the acute rehabilitation wards had been tracheostomy trained.
- Staff were designated champions for specific areas such as infection control, nutrition and dementia whilst on shift.
- Elderly care wards had a regular input from a dementia specialist nurse. On the elderly care wards dementia training was a part of statutory and mandatory training. Most staff on these wards had attended dementia training.
- New members of staff told us that they had been well supported since joining the hospital. They had completed a trust wide induction programme. The nursing staff had also been supernumerary on the ward for a couple of weeks giving them an opportunity to understand processes and procedures.
- When nurses were moved to other wards their competencies were assessed to work on those wards. We saw folders that nurses were currently working on to demonstrate their competencies to work on a particular ward.
- One doctor told us that they had recently graduated and started working at Salford Royal in December 2014.When they started they had a two week induction into the hospital and also to attend a weekly training/ teaching afternoon, there had only been one occasion when they were not able to attend due to pressure of work.

Multidisciplinary working

- Throughout our inspection we saw evidence of multidisciplinary team working in the ward areas.
- Junior doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on the medical care wards.
- Multidisciplinary Team Meeting (MDT) meetings took place on the medical care wards daily to discuss bed flow, current and new patients. The MDT meeting we observed had three junior doctors, a senior trainee doctor, ward sister, occupational therapist and physiotherapist in attendance.
- The specialist rehabilitation and strokes wards had weekly MDT meetings to plan or patients discharge. These would involve the SALT team and dietitians if required.

Medical care (including older people's care)

- Speech and language therapists attended the stroke ward regularly and patients were also referred to clinical psychologists if necessary. On the acute rehabilitation wards we saw that occupational therapists and physiotherapists were based on the wards
- On elderly care wards, patients living with dementia were assessed and reviewed by dementia specialist nurses.

Seven-day services

- Seven day a week working appeared to be operative across some of the wards and specialisms. For example the on call consultant for the
- The acute rehabilitation wards were covered by consultants on a rota basis working across the weekends.
- Physiotherapy and occupational therapy services were available for patients on medical wards, stroke ward and AMU over the weekend.

Access to information

- Staff told us they had good access to patient related information and records whenever required.
- Nursing staff told us when patients were transferred between wards or team's staff received a handover of the patient's medical condition and as patient records were electronic they were able to access them straight away.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that patients, who staff think to be cognitively impaired, were not always formally assessed for their mental capacity, and the principles of acting in best interests was not always respected. In care plans we found little evidence that that best interest meetings had taken place or the recording of them were inconsistent.
- We found that there were delays in undertaking for mental capacity assessments, meaning that some people might be inappropriately classed as lacking capacity, and are not afforded the right to make decisions about their care.
- Staff told us that mental capacity assessments were undertaken by the mental health services or doctors. A junior doctor and consultant we spoke with confirmed arrangements for capacity assessments were undertaken by doctors. However the doctor had not had any training on mental capacity act or Deprivation of Liberties Safeguards (DoLS).
- We found that where a patient was subject to DoLS and restraint mittens were being used to restrict their movement, that the two hourly monitoring checks were not being undertaken at the required frequency.
- We found that the wards electronic patient tracking board did not highlight if a patient was subject to DoLS or that mental capacity assessment or best interest meetings had taken place.

Are medical care services caring?

Good

Overall we judged medical care services to be caring. Patients received compassionate care and were treated with dignity and respect and their privacy was preserved. Patients and relative we spoke with said they felt involved in their care and were given adequate information about their care and treatment. Feedback from patients and their relatives told that they felt psychologically supported by hospital staff. Patients felt very happy about how they were looked after and complimented the staff looking after them.

The trust has a higher response rate to the friends and family test than the England average. The scores have become higher this year than last. This is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family Test highlights both good and poor patient experience.

Compassionate care

- Results of the Friends and Family Test (FFT) were displayed on every ward, and there were posters displayed encouraging patients to feed back so that they could improve the care provided. Overall these showed satisfaction with the service provided. The

wards scores varied depending on the ward, for example in July 2014 ward L3 scored 100 %, ward L8 scored 69% and the ANU scored 31%. The majority of medical care wards scored over 60%.

- Patients expressed a high level of satisfaction with the care and treatment provide when we spoke with them during the inspection. One patient said, "Nurses have been very good and very caring", another patient told us "they are on the ball with everything". A relative told us "The staff have been wonderful, I am surprised how much they do for the elderly, and I'm just so pleased". Another relative told us "I feel the nurse really cares for my nana. Nothing is too much trouble, I feel she is looked after well and will be safe when I leave. Nothing is too much for them; they are patient even when you know they are busy".
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- We looked at the results of the patient–led assessments of the care environment (PLACE).Salford Royal achieved a score of 94.2% for privacy, dignity and wellbeing against a national average of 84.7% in 2014.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors; nurses and healthcare assistants were caring, compassionate, treated them with dignity and respect and responded quickly to their needs.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.
- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns and were all very happy about the care and treatment they received.
- A patient on one of the specialist rehabilitation wards told us the "Physiotherapists work really well with me; I'm going home to try the stairs".
- We found that relatives were encouraged to support their loved ones. One relative said "my daughter comes in early to help her Nan with washing and eating and I'm here during the day. The staff have been absolutely brilliant with us".
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- On ward L6 we saw that during the ward round patients would be given a brief summary of what had been discussed with them which was dated signed by the doctor and nurse. Patients and or their relatives had the opportunity to complete a section titled "questions you want answering" and these would be followed up at the next ward round.
- On the elderly care wards we saw that patients or their relatives were encouraged to complete patient passports so that the ward staff know more about the person and their likes and dislikes.

Emotional support

- Relatives told us that the medical team had taken time to explain their loved ones care and given them a very honest appraisal of poor prognoses. The family had also been involved in discussions about pain relief which was explained in a manner and the family felt able to ask questions. The family had been encouraged to stay and visit anytime.
- During or inspection we observed that staff were responsive to patient's needs, and we observed numerous displays of kindness from motivated staff, towards patients and their relatives. One relative told us that the staff will put their loved one on the phone if necessary.

Are medical care services responsive?

Outstanding ☆

Medical care provided at SRFT was responsive to patient's needs. The acute medical unit was well established and led the way in embracing the national four hour target as 'everyone's business' and not just the responsibility of the A&E department. Extensive work had been undertaken to

reduce avoidable admissions and improve early discharges. Whilst out of hours transfers still occurred, these were kept to a minimum and reported to senior team members. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result.

Access and flow

- Once patients had been seen in the A&E department and deemed to require admission they would be transferred to the 55 bedded emergency admissions unit which was overseen by ten acute physicians. This was split into three zones, a frailty zone (which was co-managed with geriatricians), a high intensity zone and an ambulatory assessment area.
- The unit estimated that 80% of patients admitted to the medical division were managed within this unit with the other 20% being transferred to the longer stay specialist wards. There was daily 'in reach' from the specialist medical teams (e.g. Cardiology) and regular multidisciplinary board rounds to identify patients' needs prior to discharge.
- The unit also had an ambulatory care unit co-located within it. This meant that patients who did not require admission and/or could be seen as an outpatient could be managed there.
- During the day the acute take was run by a consultant acute physician. They took all referrals from local GPs and told us that since this had been instigated they had been able to deflect approximately 20% of potential admissions. They would also take referrals from the A&E department.
- In order to expedite discharges of frail patients with no current acute medical needs there were rapid response teams who were able to 'discharge to assess' to the community.
- Despite this, like most other trusts nationally, Salford Royal had experienced significant pressures in terms of the number of medical patients requiring admission over the winter period. At the time of our inspection there were 18 medical outliers (patients who were under the care of a medical consultant but looked after on a surgical ward). These patients were seen daily by the medical teams looking after them.
- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. Corporate discharge planners supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care. Discharge arrangements were discussed at the daily board rounds.
- Across the hospital bed capacity meetings were operational four times a day to establish where availability on the wards.
- To prevent delaying the time of discharge blood tests were being done the night before so that consultants had the results in the morning.
- We were told that the main cause of delays was the provision of community services, to meet patients' ongoing needs. On the elderly care wards staff told us the patients had to wait until they were declared as medically fit for discharge before social care assessments were undertaken. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.
- The inpatient discharge lounge was opened from 8.00am – 8.00pm where patients could wait for transport or final discharge arrangements such as medicines. The discharge lounge had a beverages bay so that staff could provide food and drinks.In the morning we visited we found that three older people had been brought to the discharge lounge, they were all in their night wear. On person had been in the discharge lounge for over two hours waiting for transport. We observed patients in the discharge lounge were regularly checked by the nurses ensuring comfort, nutrition and offering them meals.

Meeting people's individual needs

- Wide range of patient literature was displayed on the wards covering disease and procedure specific information, health advice and general information relating to health and social care and services available locally. Patient information leaflets were not displayed in languages other than English.
- Ward matrons told us of changes they had made to the wards following feedback from patients and relatives –

these included extending the visiting hours on some of the wards particularly the elderly care wards from 10.00am to 8.00pm and encouraging families to assist their loved ones particularly at meal times.

- There were white patient boards at back of beds which had information about the patients care needs, for example if the patient as at risk of a fall, the name of the nurse and health care assistant responsible for the patients care that day and how they liked their tea and coffee.
- The white boards would also detail what was important to the patient, staff told us these would be updated daily. The most of the comments we observed were patients wanted "to go home" or "get better"
- A blue 'butterfly' symbol was used to identify people living with a cognitive impairment on all the elderly care and medical wards.
- Blue wrist bands were used to identify patients who had a cognitive impairment. Patients who were at risk of a fall wore a red wrist band and were also offered red bed socks.
- The dementia specialist nurse visited all the care of elderly wards and also saw referrals on the other medical wards. Staff had completed basic dementia awareness training. The wards we visited had a named dementia champion.
- On the care of the elderly wards we saw that the bays were different colours to assist patients with a cognitive impairment.
- Patient passports were in use for patients who had cognitive impairment which were completed by the patient or their relative.The passports were used so that patients could to outline their care needs, preferences and any other useful information that the staff would find useful to assist with their care.
- On the elderly care wards we saw that all the bays had computer screen on display with detailed the ward people were on, where they were, the time of the day, and day of the week.
- Patients had access to bedside televisions which was free in the mornings. They were also able to use their bedside telephones to make free local calls 24 hours a day.
- All the medical care wards provided single sex accommodation with the majority of bays having shower and toilet facilities.Where showers and toilet facilities were not available within bays we saw that there were designated male and female facilities located close to the single sex bays.
- We found that patients could access a range of specialist nurses, for example in stroke and diabetes care and that these staff offered appropriate support to patients and their families.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff directed patients to 'Patient Advice and Liaison Service' (PALS) if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Ward matrons told us that they received very few formal complaints but any they did receive were usually linked to communication with relatives.
- Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved. We saw that previous months complaints were available for staff.
- Patients (and relatives) also had access to a free helpline (HELP) which they could ring which was staffed 24/7 by a senior member of nursing staff. Helping to Empower Patients and Loved-ones (HELP) system allowed every patient and family member a 3 step access process to nursing or medical directors, if they felt that a patient's management had the potential to cause harm. The system was developed following a thematic review of the Trust's Serious Untoward Incidents (SUI's) which demonstrated that patients occasionally prophesized that harm was about to occur to them. The HELP system allows patients and families the opportunity to discuss their care with senior clinical leaders outside of their allocated clinical team.

Are medical care services well-led?

Outstanding ☆

Medical care services at SRFT were exceptionally well led. Clear accountable governance structures existed and risks

were identified early and owned by individuals who were appropriately held to account. The culture within the division was one of openness and honesty. The trust wide objectives (Safe, Clean and Personal) were well known by all levels of staff and individual divisions had aligned their priorities to the wider goals of the trust. Staff development was seen as a key driver of improvement and there was evidence of widespread investment in staff encouraging loyalty and engagement at all levels. This meant that staff were empowered to identify areas within their own service to improve.

Vision and strategy for this service

- As mentioned previously medical specialities within SRFT are split between two of the main divisions of the trust – Salford Health Care and Division of Neurosciences and Renal Services. Each of these divisions are further sub-divided into smaller component parts.
- Each division within SRFT are jointly led by a Divisional Managing Director, a Chair of the Division and a Divisional Director of Nursing.
- Each division issues an annual 'Plan on a Page' depicting its vision for the year ahead and how this aligns with the trust values and corporate objectives.
- The trusts priorities for care have been summarised into 'Safe, Clean and Personal' which was depicted throughout the hospital and on staff badges. This meant that staff were continually reminded of how they should be striving to deliver care to their patients. In addition, the trust vision to be 'the safest in the country' was well recognised and owned by the staff met within the medical specialities.
- Staff were passionate about improving services for patients and providing a high quality service.
- Staff told us that they were involved in staff engagement groups to help develop the trust values and behaviours

Governance, risk management and quality measurement

- Accountability for risks within each of the divisions was shared between the divisional managing director, the chair of the division and the divisional director of Nursing. Four assurance committees within the divisions (the Divisional Operations Board, the Clinical Effectiveness & Risk Committee, the Patient and Staff Experience Committee and the Divisional Quality and Safety Committee) met monthly to provide evidence that risks were being identified and actioned upon.
- Each division had a Risk Management Strategy outlining the framework of roles and responsibilities towards risk for individuals and the committees.
- Each clinical area held its own risk register. In line with the trust wide risk management strategy, risks rated as significant were escalated to the trust board and formed part of the corporate risk register, for which, the board and executive team had oversight and responsibility for.
- The governance structure within individual divisions had undergone external scrutiny in 2012-13 specifically looking at key themes such as risk registers, service reviews, allocation of roles and responsibilities and divisional structures and board meetings. The review concluded that significant assurance could be taken throughout SRFT including the divisions responsible for the medical divisions.
- The ward staff were motivated to continually improve the service they offered and be recognised as a ward that was Safe, Clean and Personal Every time (SCAPE).To achieve SCAPE status the ward staff would need to achieve green status (meeting Nursing Assessment and Accreditation System) three times. Assessments would be undertaken every eight months meaning that achieving SCAPE status took a minimum of two years. Once achieved they would be reassessed annually.
- Staff told us that they had to worked hard to retain SCAPE status and it was evident from the pride demonstrated by ward staff who had obtained this status, that this was a sought after recognition for the standard of care they provided to their patients.
- Ward managers told us that once the ward had achieved SCAPE status they were able to wear a red uniform that distinguished them as ward matron. An annual reassessment was then undertaken to ascertain whether they had maintained SCAPE standards/ competencies. Corporate lead nurses undertaken regular unannounced reviews of the wards assessing and against thirteen core nursing standards. The Peer review audits which would highlight actions and timescales for completion.

Medical care (including older people's care)

Leadership of service

- Staff told us that they felt supported by directorate's management team, who did regular ward round and had worked alongside colleagues on the wards.
- Staff told us that they felt valued and respected and worked in a very supportive environment. A ward manager told us "you know that to work in Salford Royal you have to give 110%".
- Nursing staff from Band 5 upwards were able to access clinical leadership programmes.

Culture within the service

- Staff spoke were proud to work at Salford Royal, they were very positively about the high quality care and services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- Staff were committed to their work and to providing high quality care for patients.

Innovation, improvement and sustainability

- The trust encouraged innovation using recognised 'Quality Improvement' methodology. Approximately 130 consultants had undergone training in this and members of staff we spoke to were able to give examples of how they had been encouraged to drive change and improve their service using these forums

Surgery

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

Information about the service

The Trust has 277 in-patient and 28 day surgical beds based across 12 wards. There are 20 operating theatres. The surgical directorate is divided into two divisions; Neurosciences with Renal services and Surgery. The surgical directorate provides elective and emergency surgery to patients from the local Salford population and wider communities, such as Greater Manchester, Mid-Cheshire and areas in the Northwest for its specialised services. The intestinal failure unit is one of two national centres.

Adult neurosurgical services are based at Salford Royal Hospital and are part of The Greater Manchester Neurosciences Centre. The Trauma and Orthopaedics service acts as a tertiary centre, accepting complex referrals from the surrounding hospitals. The trauma service is led by a lead consultant and supported by orthopaedic advanced nurse practitioners and consultant Ortho-geriatricians.

We visited a number of surgical areas including; pre-assessment, day surgery, day theatre, operating theatres and the discharge lounge. We visited wards; H5 (short stay surgery), Level 3 Surgical assessment lounge, B1 (Surgical gastroenterology), B6 (Orthopaedic trauma), B7 (non-elective neurosurgery), H7 (elective neurosurgery and ENT) and ward H8 (Intestinal failure unit). We spoke with 37 patients, reviewed 10 electronic patient records and spoke with 71 staff. We observed staff interaction with patients and general activity in all areas.

Summary of findings

We have rated surgery as requiring improvement. We noted that there was a distinct variance between the management of surgical wards and the management of the theatre department. Ward based staff followed local systems and processes to ensure that patients were kept safe and were protected from harm. However, within the theatre department, we found that whilst there were systems in place to protect patients, there were some omissions by staff with regards to implementing these systems and processes. For example, theatre staff were not always completing checklists based on the World Health Organisation (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. Further there was no monitoring of this by senior staff. The trust had acknowledged some cultural and morale difficulties within the theatre department and had embarked on a quality improvement project to address the issues.

We found systems and processes were in place for ensuring patients were kept safe within all inspected wards within the surgical divisions. We saw on our visits to wards, ten of the twelve surgical wards had achieved SCAPE (Blue status) with the exception of B6 (triple green) and the Trauma Assessment Unit (amber). Theatre recovery had also attained a blue SCAPE rating. SCAPE rating was deemed to be the optimal achievable score.

Surgery

The incident reporting process was embedded in staff practice. Sharing of information, including learning from incidents took place via a number of methods; ensuring staff were fully informed and aware. Staff received mandatory safety training to support the delivery of safe care and treatment to patients.

The surgical divisions reviewed mortality and morbidity outcomes in order to identify where changes in practice were required. Staff continuously monitored their performance against required safety parameters in respect to patient safety and risks. Where risks to patients were identified, these were acted upon. Staff monitored patient's well-being in line with an early warning system, which was acted upon where concerns were identified. There were effective arrangements in place to minimise risks of infection to patients and staff. Arrangements were in place to ensure sufficient numbers of staff were on duty to support the delivery of patient care safely.

Patients were assessed, treated and cared for in line with professional guidance. There were effective arrangements in place to facilitate good pain management and monitoring of this. The nutritional needs of patients were assessed and patients were supported to eat and drink according to their needs. There was access to dieticians and the speech and language therapy team. Complex nutritional needs were addressed through experienced and suitably skilled staff. Patient surgical outcomes were monitored and reviewed through formal national and local audit. Staff caring for patients undertook training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received feedback on their performance and had opportunities to discuss and identify learning and development needs. Consultants led on patient care and there were arrangements in place to support the delivery of treatment and care through the multi-disciplinary team and specialists. Access to most allied services out of hours were in place.

Are surgery services safe?

Requires improvement

Whilst there were systems and processes in place for ensuring patients were kept safe, there were some omissions by staff with regards to implementing these systems and processes. For example, theatre staff were not always completing checklists based on the World Health Organisation (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. Further there was no monitoring of this by senior staff. This was despite there having been incidents occurring historically whereby it had been identified that a contributing factor to the incident had been an omission by staff to complete or appropriately record and evidence that a WHO checklist had been completed.

The incident reporting process was embedded in staff practice. Sharing of information, including learning from incidents took place via a number of methods; ensuring staff were fully informed and aware. Staff received mandatory safety training to support the delivery of safe care and treatment to patients.

The surgical divisions reviewed mortality and morbidity outcomes in order to identify where changes in practice were required. Staff continuously monitored their performance against required safety parameters in respect to patient safety and risks. Where risks to patients were identified, these were acted upon. Staff monitored patient's well-being in line with an early warning system, which was acted upon where concerns were identified. There were effective arrangements in place to minimise risks of infection to patients and staff. Arrangements were in place to ensure sufficient numbers of staff were on duty to support the delivery of patient care safely.

Incidents

- Staff who spoke with us in all surgical areas demonstrated their knowledge of the incident reporting process. We were told staff had direct access to the electronic system to enable prompt reporting. Weekly meetings and governance meetings were said by theatre staff to be used for incident discussion. We saw theatre newsletters were used to convey information about incidents and included reminders to staff about

safety checks and equipment preparation. Theatre staff explained that learning from incidents was discussed at meetings and described an example related to equipment and actions taken. Minutes were reviewed by us and confirmed discussion of incidents as well as audit results.

- Ward staff explained to us how information related to safety and incident reporting was fed back at 'huddle' meetings. These were said to take place as part of the shift handover. Staff were able to describe examples of safety matters discussed at these meetings. For example, a recently identified issue related to peripherally inserted cannula infections had been discussed, along with actions to improve the matter. Staff explained how learning from falls incidents had led to a system of red tagging bay areas where patients were at high risk of falls. This identified a member of staff who was not able to leave the bay unless a member of staff took over from them, which enabled them to observe and respond to those at risk of falling.
- Within the acute surgical services there had been one reported never event, stated as having been the wrong level operated on during a spinal procedure (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). We reviewed the policy for 'Correct level spinal surgery', issue 4, March 2014. This provided detailed guidance as to the measures to be taken to avoid errors.
- We reviewed formal papers, which indicated the processes for reviewing all types of incidents. For example, the paper presented in November 2014 included submission of surgical division incidents reported between the period of July and October 2014. For the period there had been 445 incidents reported, with the top five incidents as follows:

Incident type	Number of incidents
Falls	55
Communication	47
Medicine	46
Documentation/record keeping	34
Other	48

- Six incidents that had been reported between November 2013 and June 2014 had been reviewed under the SIARC process. These were incidents which needed consideration but did not fit into the trust's serious untoward incident criteria. A further three serious untoward incidents had been reviewed, including two related to acute surgical services. We saw action plans developed as a result of incident reviews, which included an overall objective, how this would be approached, a lead responsible person, date for completion and review. Staff were able to describe action taken when asked about a specific incident.
- We reviewed minutes from the division of surgery meetings and saw there was discussion of incidents as well as actions arising from the review process. For example in the 10 November 2014 minutes we saw an incident had been discussed in relation to an unwitnessed patient fall. Issues identified included gaps in nursing documentation and staff not following the protocol for looking after the patient one to one. A number of changes were requested prior to the agreement of the action plan.
- Mortality and Morbidity meetings were taking place at regular intervals and we saw the schedule for the year set out by surgical speciality. We saw minuted discussion of mortality and morbidity within Neurosurgical and Renal Divisional Assurance and Risk Committee (DARC) action reports for various months across 2014.

Nursing Assessment and Accreditation System (NAAS) & Safe, Clean and Personal Care Every Time (SCAPE)

- A nursing assessment and accreditation score process formed part of the performance targets for surgical wards. These were said by matrons to be linked to the principles of 'Safe, Clean and Personal care to every person, all of the time', (SCAPE). Wards were assessed and the outcome resulted in a colour score, with opportunities for improvement through re-assessments at four monthly intervals. Ratings were given based on the assessment of specific criteria. We saw on our visits to wards, a green rating had been achieved by B6 (Orthopaedic trauma).B7 (non-elective neurosurgery

and renal), and H7 (elective neurosurgery and ENT). The theatre recovery department had attained a blue SCAPE rating. SCAPE accreditation (blue) was deemed to be the optimum achievable score.

Safety thermometer

- Surgical wards collected and reported information on a number of safety parameters, linked to individual patient risk assessments. We saw results displayed on entry to wards as part of their performance targets. Information included for example, the number of days since a patient had fallen on the ward. It was reported by B1(Surgical gastroenterology), that two days prior to our visit a patient had fallen and on B6 it had been 45 days since a patient fell. On H7 it was 15 days since a patient reported fall.
- The surgical division harm dashboards also recorded incidents of patient falls, which resulted in major or catastrophic harm.There were no reported falls where patients suffered major harm between April and October 2014 for the Neurosurgical and renal division. However, there was one reported patient who suffered catastrophic harm in April 2014 within this division. There were no reported patient falls resulting in either major or catastrophic harm in the surgical division for the same period.
- Surgical wards also displayed information on hospital acquired pressure ulcers. We saw from information displayed that on B1 it had been 1,217 days since a pressure ulcer had been acquired by a patient receiving care there. On B6 they reported 180 days since a hospital acquired pressure ulcer. H7 indicated it had been 515 days since a patient had developed a pressure ulcer.
- There were procedures in place to ensure that patients having theatre procedures had pressure relieving devices, such as gel and heel pads. In particular patients having extensive spinal surgery who were positioned on the operating table in a prone position for up to 12 hours and were therefore more prone to acquiring pressure ulcers, were assessed both before and during surgery to ensure that appropriate action was taken to reduce the risk of harm caused by pressure damage. Other measures used by theatre staff to ensure patient safety included use of patient warming aids, fluid warming before administration and checking of the patient skin condition on arrival to theatre and again in recovery. We saw these checks were recorded on a body map record.
- The surgical division produced dashboards, which indicated the number of patients who suffered harm as a result of hospital acquired pressure ulcers which were categorised as grade two or above. Results for the period April to October 2014 indicated two patient incidents in May 2014 and three in September 2014 for the Neurosurgical directorate. An elevation was noted in May 2014, of which two cases had been reported and one further case in June 2014 on the surgical harm dashboard. We noted a grade 4 acquired pressure ulcer was reported on the surgical harm dashboard in June 2014.
- Level one theatres reported one pressure ulcer in July 2014 and one in September, both of which were grade two.
- Patients admitted for surgical procedures were required to have an assessment of their risk of developing a venous thromboembolism (blood clot in the vein). Ward staff carried out audits on the completion of venous thromboembolism (VTE) assessments. We saw from patient electronic records reviewed assessments had been carried out and where actions were required, such as the application of anti-embolic stockings or the administration of prophylaxis medicine, these were carried out.
- The Trust had produced a patient safety film, accessible via the internet and the patient bedside entertainment system, which was designed to provide patients with information about keeping themselves safe whilst in hospital. We viewed the film and saw it contained simple but important pictorial information regarding avoiding slips and falls, changing position in order to avoid pressure damage to skin and mobilising to avoid blood clots.

Cleanliness, infection control and hygiene

- Theatres and wards had infection prevention and control (IPC) link nurses. Staff told us they attended IPC meetings and we reviewed minutes of these meetings.
- The theatre lead had initiated a monthly meeting, which commenced in November 2014 in order to support IPC practices in the team. The first IPC audit carried out

following the initial meeting achieved a poor score of 56% overall for theatre eight, level three. The December 2014 audit for the same area showed an improvement with a score of 79%. We saw information, which reported theatre five and the domestic room scored 88% and 86% respectively in the IPC audit carried out in December 2014. The January 2015 audit of recovery and the 'dirty corridor' (named as such as this is the route used to take waste and dirty instrumentation from the theatre areas) achieved a 100% and 86% audit score respectively.

- We were told a new dedicated housekeeper had been appointed for theatres and practices had improved. The theatre lead received a regular audit report from cleaning services.
- On inspection, operating theatres were found to be visibly clean and there were separate clean preparation areas and facilities for removing used instruments from the operating room to the hospital's decontamination unit.
- Staff told us theatres were cleaned at night, with theatre staff cleaning during the day between cases. We were told theatre equipment was cleaned by staff and saw items that had been cleaned were recorded on level three. However, there was no record for the cleaning of equipment on level one. Equipment checked by us was found to be visibly clean in preparation for use.
- We found all surgical ward areas we visited to be suitably clean. There were formal arrangements in place to direct domestic staff as to the required levels of cleanliness and routines; ward bed areas were cleaned daily and deep cleans of clinical areas were carried out weekly. Domestic staff had been provided with appropriate colour coded cleaning equipment, which enabled them to minimise risk of cross contamination.
- Patients who commented on the cleanliness of the ward were generally satisfied. However, one patient who spoke with us in the discharge lounge said their bed area on the orthopaedic ward was not cleaned for four days. They reported this to the nurse in charge and cleaning thereafter happened daily.
- Surgical staff were seen to follow National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008).
- All technical equipment used on wards for the provision of patient care and checked by us was found to be clean. We also looked at commodes and bathing equipment such as assisted baths and these were all suitably clean and ready for use.
- We noted there was easy access to personal protective equipment such as gloves and aprons and staff used such items for various activities. This included patient care and during meal services.
- Staff compliance with local infection control policies was noted to be good, with all staff bare below the elbows to enable thorough hand washing. Access to hand washing and drying facilities was readily available and signage at wash stations instructed on the correct methods for removing possible contaminates was displayed. We saw regular use of these facilities by staff in addition to hand decontamination gel, the latter of which were either carried by the nurse, as well as being located at the patient bed.
- We observed staff complying with policy in respect to the handling and management of clinical and domestic waste. We saw bed linen was handled in accordance with best practices and sharps were disposed of safely.
- The handling and management of surgical specimens in theatres was noted to be safe.
- Isolation signage was in place where required in the form of a small orange triangle applied to the patient door. There was no additional information to accompany this such as instruction to visitors to speak to staff before entering the room.
- Data reviewed prior to the inspection showed the Methicillin Resistant Staphylococcus aureus (MRSA) rates were better than the England average up to August 2014, with one case was reported. Clostridium Difficile (C.diff) infection rates were better than the England average for the majority of the period reported.
- Wards displayed information, which indicated the number of days since they had MRSA or C.diff. For example on B1 it was 3,132 days since MRSA and 3,689 since they had a case of C.diff. On B6 it had been 1,407 days since a case of MRSA and 12 days since C.diff. Ward H7 reported 1,205 days since a case of MRSA and a similar number of days in respect to C. Diff. Following the inspection, the trust reported that the information

displayed on ward B6 was incorrect and the actual, verified data should have reported 2,328 since the last case of MRSA and 563 days since the last reported case of C.diff.

Environment

- The environment in which surgical patients received investigations; treatment and care were suitably safe. Operating departments were arranged as two business units, B1 and B2, and on two levels; one and three. Admission lounges and day case surgery suites were available on each level.
- Spinal work was moved recently to level one from level three and trauma and orthopaedic surgery moved from level one to three. This ensured all trauma work was based on one floor.
- All theatres had associated anaesthetic rooms, clean and dirty areas, and a recovery department.
- Wards were in the main arranged with bay areas and some separate single rooms. There was provision for waste disposal on every ward. Staff had separate storage areas for clinical equipment and medicines.
- We observed the paediatric recovery bay within the Surgical Day Care Unit: resuscitation equipment for children was up to date and fit for purpose. The paediatric operating theatre was close to the recovery area and recovery staff had been trained in paediatric life support techniques.

Equipment

- We noted operating department practitioners were not recording in the logbook provided that they had checked anaesthetic equipment prior to use. Anaesthetists were carrying out checks as part of their procedure and recorded this within the patient surgical pathway documentation. (Anaesthetic staff had a responsibility as set out in the Association of Anaesthetists of Great Britain and Ireland safety guidelines: Safe Management of Anaesthetic Related Equipment (2009). This includes the following: A clear note must be made in the patient's anaesthetic record that the anaesthetic machine check has been performed, that appropriate monitoring is in place and functional, and that the integrity, patency and safety of the whole breathing system has been assured. A logbook should also be kept with each anaesthetic machine to record the daily pre session check and weekly check of the oxygen failure alarm. Modern anaesthesia workstations may record electronic self-tests internally. Such records should be retained for an appropriate time. Documentation of the routine checking and regular servicing of anaesthetic machines and patient breathing systems should be sufficient to permit audit on a regular basis.
- Staff confirmed there was no formal auditing of safety checks having been carried out.
- We fed our concerns back to the executive team on completion of the announced inspection period. We were provided with updated audit data on 27 February 2015 which demonstrated that the trust had introduced a new audit programme to ensure that the necessary checks of equipment was routinely being undertaken in theatres; this audit programme was scheduled to continue for an additional 7 weeks, producing 12 weeks of audit data overall. Provisional data demonstrated that there had been improved compliance with regular, daily safety checks being undertaken although we have not undertaken a site visit to verify this.
- Resuscitation equipment was easily accessible in all surgical areas we visited. We saw that daily checks had been carried out of this equipment on the majority of the days. Staff also had access to other emergency equipment. We saw emergency equipment for intubation in theatre and tracheostomy equipment on the ward.
- Arrangements were in place to service equipment, including portable electrical items and we saw evidence of such checks on equipment. Staff told us they had enough equipment to enable the safe and effective delivery of care.
- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- Surgical instrumentation which required decontamination between uses was outsourced to an accredited unit, with a service level agreement in place.
- Staff working in theatres told us there was insufficient equipment at times, particularly since the move of the

specialities. We saw in the surgical directorate report for December 2014 that there had been three reported cancellations due to lack of equipment, including one case where equipment had not been ordered.

- The surgical directorate report included reference to a shortfall in instrumentation and a cost analysis. A business case was to be completed for anaesthetic machines, surgical instruments and equipment.

Medicines

- Ward staff told us they had designated pharmacy support, with regular visits to the ward and reviews of patient prescriptions. Pharmacy technicians visited wards daily and picked up requests from a communication book. All new patients were reviewed in respect to their medicines.
- Medicines were noted to be stored safely, either within locked medicine trolleys, chained to the wall or within designated key accessible rooms on wards. Controlled drugs (CD) were locked within a secured wall cabinet within this same secure room. Alarms were attached to CD cupboards, indicating when the cupboard was being accessed. We checked CD registers and saw full records had been completed in regard to checks and administration.
- We observed CD's being prepared, checked and administered by nursing staff in accordance with safe practice. We saw medicine administration rounds taking place on wards and noted staff were undertaking their duties to expected standards of practice.
- Staff were required to follow hospital policy and undertake daily checks of the temperature of fridges where medicines required storage under a temperature control. We saw checks had been carried out on wards but within theatres on both levels some of the checks had not been carried out. For example in one anaesthetic room located within level one theatre, there were no temperature checks recorded between 01 and 13 January 2015. Temperature checks on storage units holding fluids which needed to be warm prior to use in theatres on level one were not being undertaken. Staff were not aware of the importance of ensuring that the temperature should be routinely checked and recorded. It was noted that the same storage units managed by level three staff were routinely checked and recorded. There was a risk that medicines and fluids may not have been stored at the correct temperature.
- Staff explained the process for reporting medication errors, which included an example of a recent incident. In line with the services positive culture toward being open and transparent about incidents, the patient and consultant had been informed and the incident formally reported. The member of staff completed a formal reflection on the incident and was supported by the learning and development team.

Records

- The surgical division used electronic patient records (EPR), which included all relevant information about the patient, for example, their demographics; medical and surgical history, allergies, medicines and standard risk assessments. The latter included risks related to mobility, moving and handling, pressure areas and nutrition.
- On B7 ward we found some inconsistencies in the risk assessment for two patients related to pressure areas. There were different grades scored for pressure ulcers and conflicting information as to whether the ulcers had been acquired in the hospital or community. On discussion with the ward manager they were not able to explain this.
- We reviewed 10 EPR's. We noted that although the patient record and associated care pathway was mostly electronic, the theatre element of the patient pathway was paper based. This presented a problem in that the electronic record would not allow movement to reset relevant sections unless it had been completed.
- There were separate paper documented care pathways for staff to follow in relation to some aspects of patient care. For example we saw care pathways for External Ventricular Drains and elective surgery pathways.
- Staff told us the daily co-ordinator was responsible for making sure all EPR's were up to date and care bundles, such as central lines and cannula checks were completed.

Safeguarding

- Staff explained to us that they undertook safeguarding training. Safeguarding training was a mandatory

subject. Staff who spoke with us were able to demonstrate their knowledge and understanding of safeguarding vulnerable individuals, including signs and symptoms and the action to be taken.

- There was a good awareness of the safeguarding lead from ward and theatre staff.

Mandatory training

- Staff confirmed to us that mandatory training included sessions related to patient safety, such as; manual handling, life support, fire, infection prevention and control, as well as mental capacity.
- Figures provided by the surgical division indicated 95.2% of general surgical staff had completed their mandatory training. Completion of this training had been completed by for example, 94.4% of staff working in Trauma and orthopaedics and 95.9% of theatre staff. 100% of staff working on level three surgical admissions unit had completed their mandatory training.
- Staff told us they were required to complete their mandatory training as this was linked to their performance and pay review. They also explained that they would be suspended if they did not complete required training within the designated time period.
- A formal process was in place to alert staff of the need to complete their mandatory training. This included a formal alert generated 90 days in advance.

Management of deteriorating patients

- Once the patient was in recovery following their surgery the electronic record was used by staff. Staff undertook patient observations, such as their heart rate, respirations and temperature, entering the results onto the early warning monitoring system (known as NEWS). Staff in recovery level three, where patients with more complex needs were recovered reported the NEWS was not working well for them. This was because there was only one computer port between two bays and as a result observations were taking longer to complete and enter. Staff within level one recovery said the electronic NEWS worked for them.
- We saw from reviewing EPR's the NEWS system enabled automatic alert of patients who were unwell and needed to be seen by a doctor. Recovery staff reported that the anaesthetist was always prompt in responding to concerns. Ward staff told us how they escalated deterioration in patients by calling the relevant grade of medical staff.
- There was an emergency number for staff to call the arrest team and staff were aware of this.

Patient Safety

- We saw guidance to theatre staff in respect to following the five steps to safer surgery, which included team brief, sign in, time out, sign out and debrief.
- Both operating theatre suite lead nurses (level 1 & 3 confirmed that staff carried out the five steps and that the anaesthetic department had carried out a qualitative review of the briefing and debriefing process in Sept 2014. The report from this highlighted concerns about the process not being embedded and identified emerging themes around distractions and interruptions.
- The action from this stated that a qualitative review would carry on in just one theatre, (which would limit the quality of data). Staff appeared to accept that the qualitative review in some way replaced the need to monitor compliance. Data provided by the trust suggested that the "Team brief, Sign In and Time Out" components of the checklist were embedded in to practice but that "Sign out" was "Still forgotten and the most poorly performed of all of the checklists", "Silent focus is often not observed", "Elements are missed as there is no aide memoire" and "Debrief has been difficult to capture due to 3 session working".
- Following a surgical procedure in 2013 where a wrong site surgery had taken place, it was noted that the WHO checklist had either not been completed or was missing from the patients notes. An action from the never event was to ensure that the WHO checklist was completed for each surgical procedure. We further noted that WHO checklist audits were required to be undertaken as a means of assuring the department that appropriate systems and processes were in place to reduce the risk of similar incidents occurring in future.
- During the inspection we found that theatre staff were not reliably completing checklists based on the World Health Organisation (WHO) safety procedures to safely manage each stage of a patient's journey from ward

through anaesthetic, operating room and recovery. Further there was no monitoring of this; staff said they were waiting for the checklist to be put into the electronic system.

- When asked for evidence that the 5 steps WHO process was in place and working, both lead nurses explained that they no longer monitored it. They said that it would eventually become an electronic document and that would enable them to monitor it more easily. There was mention that one theatre was going to trial scanning in the completed 5 steps process. This was also documented in one of the theatre audit meeting minutes.
- Due to the lengths of some surgeries whereby patients may be at risk of developing skin pressure damage, nursing staff reported that patients were occasionally referred to the assessment unit so that they could be positioned on an operating table in advance of their proposed surgery; this enabled the surgical team to determine any areas of skin which may be exposed to pressure over a period of time. This enabled the team to introduce measures to reduce the risk of the patient developing pressure damage during surgery.

Nursing staffing

- Staff told us they did not use a specific acuity tool to identify and agree staffing levels but worked on the principle of one trained nurse to eight patients. Matrons explained that staffing levels were reviewed three times each day to ensure levels were safe.
- Staffing levels were displayed outside each ward. These specified the number of trained and support staff required on each shift, as well as what they actually had on duty on the day.
- We asked to view duty rotas and these were electronic based. Where gaps were identified in shifts these were said to be back filled with bank staff, many of whom were regular contracted staff. A separate electronic record was completed for booking such staff.
- The wards reported staffing figures on a monthly basis as part of the safety report. These were publicly available on the hospital internet. We viewed the months August to November 2014 for surgical wards and found the percentage of trained nurses varied on the surgical wards during day shifts from the lowest at 79.9% on B8 (Neurosurgery) in August. On night shifts the lowest percentage of trained staff on duty was reported in August at 83.7% on the short stay surgical unit. The trust reported that bed occupancy for August 2014 was 59% and as a result the total number of staff required to support clinical areas was lower; nurse to patient ratios were reported as never exceeding 1:6 and so staff were moved pragmatically across the service to ensure all clinical areas were appropriately staffed at all times.
- The admissions lounge on level three was staffed by two registered nurses and one support worker per shift. Management support was said to be available from the operating department practitioner in theatre. If required additional help would come from staff in other departments; agency staff were not used.
- There were 413.93 whole time equivalent (WTE) nurses in post within the surgical area. Theatre staff said there were seven vacancies, adding that recruitment was difficult. Regular agency staff were being used in these theatres and there was a formal induction process in place for these individuals.
- Theatre staff reported having staff shortages but there had been three support workers recruited to help the anaesthetic operating department practitioners.
- Theatre staff stated skills mix was sometimes a concern, particularly as operating lists could change at late notice and after skills had been considered in the allocation of shifts and responsibilities. The impact of this was that junior staff were sometimes on duty without senior staff for support. Staff said they reported this to management but often there was little that could be done. Management told us they would cancel a case if they thought it would be unsafe for the patient.
- Additional support worker staff were said to have been recruited in theatres. This was said to have happened as a means of assisting the operating department practitioners undertake their safety checks so that theatre lists could start on time.
- Matrons confirmed they were not counted in the numbers and therefore, were able to undertake their duties effectively. They did say they would undertake nursing tasks as a natural part of their engagement with patients and staff on occasion.

Surgery

- The pre-assessment service was staffed by 17 trained staff and there were arrangements in place to cover sick leave, holidays and training.
- A patient on ward B7 commented on the staffing and said, "Two nurses trying to do the job of three, they're angels." A patient who spoke with us in the discharge lounge following discharge from the orthopaedic ward told us the response times from nurses was at times eight to 10 minutes. They said nurses appeared stressed and nurses were moved to other wards despite being short themselves.
- Ward staff said they had formal patient handover in between shift changes, with discussion as a team and then bed side handover. Healthcare support staff said they were given direction as to what patients required for the shift, such as assistance with hygiene or feeding. They did not use the electronic record to identify specific ways to support people's individual needs.
- Patients were collected from wards by theatre support staff prior to surgery and following surgery the support or recovery staff returned patients to the ward and handed over relevant information.

Surgical staffing

- We were told there were 274 medical staff, of which were at 44% consultant level, 5% middle career, 38% registrar and 13% junior trainee doctors.
- Information pertaining to the rotas for medical staff was displayed on wards. This included contact details and names of those providing on-call services for out of hours and weekends.
- Theatre staff confirmed consultant surgeons led on patient treatment.
- Staff confirmed there were two full-time and one part-time Ortho-geriatrician's, who covered ward B6 and outreach services.
- Medical staff confirmed there was a formal handover of new patients and any problems as part of the shift change.
- We saw from rotas and heard by direct conversation that medical locums were used to back fill gaps in the medical staff rota.
- Consultant led care was provided 24 hours per day, seven days per week, with on call arrangements for night and weekend hours. Speciality consultants were said to be taken out of the elective list when on the on-call rota.

Major incident awareness and training

- We were able to view the Business Continuity Policy (April 2014). This set out the incident management plan and responsibilities of staff to ensure business continuity and associated policies.
- Staff were able to access the trust policy for major incident management and business continuity. Theatre staff reported two recent power failure incidents and described how the back-up generator came into play. They said there was good communication regarding the matter.
- There were arrangements in place for deferring elective activity to prioritise unscheduled emergency procedures within the winter pressure surges plan.

Are surgery services effective?

Good

Patients were assessed, treated and cared for in-line with professional guidance. There were effective arrangements in place to facilitate good pain management and monitoring of this.

The nutritional needs of patients were assessed and patients were supported to eat and drink according to their needs. There was access to dieticians and the speech and language therapy team. Complex nutritional needs were addressed through experienced and suitably skilled staff.

Patient surgical outcomes were monitored and reviewed through formal national and local audit.

Staff caring for patients undertook training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received feedback on their performance and had opportunities to discuss and identify learning and development needs.

Surgery

Consultants led on patient care and there were arrangements in place to support the delivery of treatment and care through the multi-disciplinary team and specialists. Access to most allied services out of hours were in place.

Evidence-based care and treatment

- We saw in theatres that all local polices were up to date and referenced. Policies were accessible on the trust internet and where relevant, made reference to professional body guidance and published research papers.
- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.
- The orthopaedic service complied with NICE guideline CG124: Hip fractures – The management of hip fractures in adults.
- Within the theatre department we saw staff adhering to NICE guidance on infection control and preventing surgical site infections.
- Clinical and nursing staff followed NICE guidance on falls prevention, fractured neck of femur, pressure area care and venous thromboembolism. We saw that staff had protocols for administration of medicines admitted on the day of surgery and guidance related to anti-coagulant therapy.
- Pre-operative investigations and assessment were carried out in accordance with NICE clinical guidelines. This included guidance regarding contraception pill and hormone replacement therapy.
- We observed evidence of staff providing care in line with NICE guidance CG50: Acutely ill patients in hospital, recognising and responding to acute illness.
- Patients receiving post-surgical care were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital.
- The surgical division had or were undertaking an extensive range of local audit activities, many of which were in progress and yet to be reported on. Completed local audits included prescribing of paracetamol in surgical patients weighing less than 50Kg, outcomes following trans-vaginal tape surgery in relation to National Institute for Health Care Excellence (NICE) and the quality of orthopaedic clerking. We reviewed the audit reports for these and saw that there were recommendations and actions taken as a result of the findings.

Pain relief

- We visited the pre-assessment unit and saw that staff followed a specific pathway where patients met the criteria for referral to the pain team pre-operatively. This included inclusion and exclusion criteria, such as; previous bad experience, significant opioid use, drug dependency, established chronic pain and significant anxiety of post-operative pain.
- There was a dedicated pain team, led by the anaesthetic department. Recovery staff had been trained in epidurals and syringe pumps and this was documented in their training files. Pain assessment tools were in place and used as part of the patients care pathway.
- There was a standard procedure in place to provide patients with a fractured neck of femur facia iliac block for pain relief.
- The majority of patients who spoke with us said they had their pain assessed by nurses and when required they had been given pain relief promptly. One patient on the surgical admissions unit told us their pain relief was, “not good” and they required more. Another patient said, “I am on medication for pain relief and I feel my pain relief is managed well.” This patient added that they had a direct number to the pain management doctor.
- A patient on ward H7 explained how they had transferred from another regional hospital and they had been left in pain for a long time there. They said, “This doesn’t happen on this ward as nurses are always asking if I am in pain.” We were able to witness nursing staff asking patients about their level of comfort and pain as part of their ‘intentional rounding’ checks, which took place at hourly intervals.
- We saw prescription charts for patients contained pain relief where required and when administered by staff; the relevant sections had been completed.

Surgery

Nutrition and hydration

- Staff completed an assessment of patient nutritional status and their needs as part of their initial assessment and updated this during the duration of their stay.
- We saw that staff used a colour coded tray system to indicate those who needed to be fully assisting with eating and drinking (red tray), those who need to be supported partially supported because of a cognitive impairment (blue tray) and cream tray for all others who were independent.
- Some patients were received their nutrition via specialised feeding tubes and in each case; their electronic patient record detailed their requirements including feed type and frequency was prescribed, with monitoring of intake and output.
- We saw that where individuals required supplements to their diet these were provided.
- The dietician and speech and language team (SALT) were involved in decisions about patient treatment. A patient said during the nurse led ward round they had been seen by the dietician about their diet.
- We observed the surgical wards had protected meal times, which meant that unnecessary interruptions did not take place during this period.
- The Trust website indicated that they were able to provide a menu choice for all patients including those with religious or cultural requirements or on special diets. They specifically mentioned menus for Kosher and Halal food. We saw specialised diets had been made available for diabetics as an example.
- Theatre staff told us they had updated the nil by mouth procedure as a result of changes in theatre lists and delays, which meant patients were sometimes starved for longer than expected. The revised policy allowed for flexibility, taking into account such delays.

Patient outcomes

- The re-admission rates for non-elective neurosurgery, trauma and orthopaedics were worse than the England average. The risk of readmission was higher than the England average for elective general surgery and trauma and orthopaedics. Managers told us they had not identified any concerning issues which may have contributed to these figures.
- Figures presented in the corporate performance report for November 2014 indicated the rates of re-admission across the surgical division month by month; there had been 75 surgical emergency re-admissions in November 2014. For the neurosciences division there had been 18 surgical patients.
- We saw formal documentation, which demonstrated the readmission rates for neurosurgery were formally reviewed and work had been done to address alternative pathways for re-admission. This included introduction of a 'Hot clinic', where the patient could seek telephone advice from a doctor. If necessary an appointment could be made for the patient to be seen by a senior trainee doctor.
- Staff reported that on occasion surgical patients were not admitted to the speciality ward initially, as a result of bed availability. They advised that the electronic patient record enabled medical staff, including the consultant to identify where their patients were located. In addition the handover of newly admitted patients facilitated communication of this information.
- Patient reported outcome measures (PROMS) indicated the surgical division performed worse than the England average for knee replacement but better for groin hernia and hip surgery.
- The Trust participated in the national bowel cancer audit and data reviewed for the 2013 identified that two areas where the trust scored better were as follows: Patients individual cases discussed by the multi-disciplinary team achieved 100%, against an England average score of 97.8%. Clinical nurse specialists saw 96.8% of patients at the trust in comparison to 87.7% across the England average.
- National Emergency Laparotomy Audit data results for 2014 presented a mixed picture, with some figures being available and others not. Figures not available related to; availability of the critical care outreach team 24 hours per day 7 days per week, a policy for anaesthetic seniority according to risk and formal handovers for other surgeons. Figures available included having a minimum four tier Emergency General Surgical (EGS) rota at all times. A four tier EGS rota meant that there would always be a consultant surgeon (CCT holder), middle grade (MRCS holder), core trainee and

foundation doctor available. Consultant pathology advice was indicated as being available 24 hours per day and there being at least bi-monthly reviews of all deaths.

- The Trust performed better than the England average in relation to eight areas covered in the National Hip Fracture Audit for 2014. For example; 64.5% of patients were admitted to orthopaedic care within four hours at the trust, against an average England score of 47.4%. The percentage of patients who had their surgery performed within 48 hours at the trust was 72.1% compared to the England average of 71.7. 95% of patients underwent a geriatric review within 72 hours of admission. This was better than the national average of 81.6%.
- Returns to theatre were monitored by senior staff and had been discussed at governance meetings. Staff reported that all returned to theatre were investigated and they advised there had been very few of these.
- The surgical division had policies in place to guide staff in respect to patient access, which included determining priorities.
- We saw evidence that the surgical division followed the Royal College of Surgeons standards for unscheduled care, such as having consultant led care, prioritising the acutely ill patient and ensuring that preoperative, perioperative and postoperative emergencies led to appropriate outcomes.
- Increased length of stay was attributed by staff to the nature of neurological and emergency surgery carried out. Staff had identified difficulties in discharging patients to the wider community beyond Salford. Patient pathways had been developed and were used for Salford patients but not necessarily for other referral areas. In particular the need for rehabilitation beds was impacting on the length of stay.
- The infection prevention and control annual report confirmed that there was mandatory reporting of surveillance of wound infections following orthopaedic surgery for hip replacement, knee replacement, repair of fracture neck of femur and open reduction of long bone fractures. We noted that infection rates were worse than the national England average for the period January to March 2014. This included; a 2.1% score for hip replacement against an average of 0.6%. In reduction of long bone fractures the trust scored 5.6% against a national average of 1.3%. For repair of neck of femur the trust scored 2.6% against an England average of 1.5%.
- Surgical site surveillance was also taking place in general surgery and neurosurgery specialities. The highest rate identified was for the period January to March 2014 in general surgery, with a 5.4% score.

Competent staff

- Staff told us there was a human resource process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- Appraisals were said to include supervision feedback and provided opportunities for discussion of development needs. The appraisal process was linked to salary increments and staff were expected to demonstrate how they had fulfilled the values espoused by the trust.
- Appraisal rates within the medical staff for the surgical directorate were said to be at 88%. It was recognised that there were not enough appraisers and the senior managers were keen to identify others who were willing to train to undertake this duty.
- Nursing and theatre staff were required to complete competencies in various aspects of their roles. For example, intravenous drug administration, cannulation and taking blood specimens. Staff working in orthopaedics said they were required for example, to be proficient in traction and splinting.
- 100% of anaesthetic advanced practitioners, general surgery specialist nurses and surgical day case nurses had completed adult life support training. Additionally, 100% of the listed health care professionals had completed training in aseptic non-touch technique competency based training; surgical day case nursing staff were the exception where the uptake of training was 92% for ANTT.
- An occupational therapist told us they had received a good induction and they were acquiring their competencies through supervision and small group teaching sessions.

- Dedicated practice co-ordinators were in place to ensure staff developed the required skills to use equipment and role related competencies.
- Newer members of nursing staff confirmed they were going through a preceptorship pathway and met with their mentor, initially daily but as they had progressed, weekly. This helped them to develop their confidence and competence.
- Staff said they had access to professional development, which included such areas as leadership, and end of life training.
- Staff told us they had access to policies and procedures to guide their practice and cited examples of guidance they followed to ensure care was delivered safely. This included sepsis and tracheostomy care pathways, both of which we reviewed.
- Patients told us they had confidence in the staff. One comment made to us by a patient was, "I have confidence in the staff here. I feel the staff have pride in their work." Another patient said, "the staff have dealings with are very competent."
- Revalidation was said by senior managers of the surgical division to be good.
- Information on comparative outcomes by clinician for neurosurgery and orthopaedic specialities was reviewed on the NHS choices website. We saw named consultants with indications of their outcomes as being within the expected range.

Multidisciplinary working

- Theatre staff reported having a good working relationship with other departments, such as; Radiology, Pharmacy, Pathology and wards.
- Staff indicated there was good working relationship with members of the multi-disciplinary team (MDT) and confirmed there were MDT meetings at regular intervals, including daily morning MDT's on ward B6 (Trauma and orthopaedics).
- We spoke with the ortho-geriatric specialist nurse who explained the multi-disciplinary approach to managing the hip fracture pathway. Bi-monthly collaborative meetings took place with input from; A&E consultant, consultant ortho-geriatrician, surgical and anaesthetic lead, occupational and physiotherapy and sometimes the musculoskeletal radiologist. This meeting enabled them to focus on best practice and performance and to conduct mortality reviews.
- There were arrangements in place to continue patient care at home where patient had intestinal problems. Home care staff had been trained by the staff on the intestinal failure unit on the Salford protocol. This helped patients receive continuity of treatment and care.

Seven-day services

- Staff confirmed there was access to surgical consultant out of hours. Surgeons were said to have specific working days and picked up patients from the on call rota. Ward rounds by consultants took place on an ad-hoc basis but patients were seen daily by a senior trainee or senior doctor.
- During the night, emergency admissions were said by staff to be seen by the senior doctor.
- Three theatres were open at weekends for emergencies, trauma and orthopaedic work.
- A dedicated Radiographer was available seven days a week to theatre staff, with on call out of hours.
- Physiotherapists saw ward patients and covered clinics. In addition, they were said by staff to see all new patients over the weekend and those who were operated on during the Friday.
- Pharmacy support was said by staff to be available between designated hours on a Saturday and via on-call arrangements out of hours.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The elective surgery care pathway incorporated formal consent forms and supporting information to both staff and the patient. These consent forms were in line with current Department of Health guidance. Consent forms identified the procedure to be undertaken, its associated risks and there were documented records of the health care professional responsible for consulting the patient and also recorded signatures from patients indicating that they were providing consent to undergo any proposed procedure.

Surgery

- Staff working in theatre described their role in supporting a patient who had learning difficulties. We observed a carer had been able to be present in the recovery area to support this individual and to help reduce the patient's anxiety or distress.
- Theatre staff were very familiar with consent and capacity processes but explained that issues were usually addressed at ward level prior to arrival at theatre.
- A newer member of nursing staff explained how they sought consent before undertaking any care activities. They said they did this by introducing themselves to the patient, explaining what they were going to do and asking the patient if they were happy to proceed.
- Ward staff explained that the ortho-geriatrician reviewed all patients and completed deprivation of liberty safeguard forms. Best interest meetings were said to be held with all relevant people including, but not limited to, patient's family members, advocates, physiotherapists and occupational therapists.

Are surgery services caring?

Good

Most of the patients that we spoke with expressed their experiences of using the hospital to us positively. Comments included, "They are awesome" and "nurses are attentive." We observed nursing and other staff to be kind, caring, compassionate and caring whilst undertaking their duties.

Patients said the staff respected them and their dignity was maintained during their stay. We saw staff were respectful, courteous and ensured privacy was afforded to patients during care delivery.

Patients reported they were given detailed information, sufficient to help them make informed decisions. With the exception of the minority of patients, we were told by patients they had been kept informed of their progress and understood the arrangements for treatment, care and discharge.

The emotional needs of patients were taken into account and patients were provided with support from specialist nurses, chaplaincy and psychologists where needed.

Compassionate care

- On all wards we visited we witnessed caring, friendly and positive attitude of staff towards patients and relatives. We observed physiotherapy staff supporting a patient to mobilise on ward; the manner in which this support was provided was respectful and compassionate.
- Friends and Family test results for the period April 13 to July 2014 indicate an average response rate of 35% in comparison to the England average of 32%.
- Ward HB2, B7 and TAU were consistently the same as or better than the national average with regard to the number of patients who would recommend the service between August and December 2014.
- Feedback from patient responses was displayed outside wards and included 'you said we did' comments. For example, on B7: You said comments including patients saying that they did not always having confidence in nurses. The trusts 'We did' response included increased regular communication and answering of questions.
- Staff were able to describe to us how they involved and respected people's decisions about their care. For example, where a female patient preferred to have a female member of staff help them with personal hygiene.
- On ward H7 patients expressed numerous complimentary comments in respect to the care they had received. For example, "The nurses are always there on time." "They can't do enough for you." "Care is excellent, they look after us really well." Another patient on this ward said, "The nurses are wonderful, all smile and make me feel welcome, I am very grateful."
- Patients on ward B7 (male neurosurgery) described nurses positively, one comment made was the nurses are, "Absolutely brilliant here." Patients on B1, in general, spoke positively about the nursing care and staff. However, one patient reported that some staff were, "not so good." When questioned further, they added, "Because of their attitude and the way they spoke to me."
- Other patients told us they felt safe with the staff and in the hospital environment. One patient told us, "The doctor I am under is brilliant." They added, "It's all organised and runs smoothly.

- Patients on the surgical admissions lounge reported to us that staff treated them with dignity and respect. Comments made with regard to this included; "I feel that I was treated with respect, compassion and dignity."
- We received concerning information from one patient in relation to a lack of respect and personal dignity experienced whilst they received care on ward B7. A request for a commode was forgotten about by the nurse, resulting in upset and distress to the patient. This patient also said on numerous occasions when they required assistance, such as toileting, they were being rushed. They said, "Some say hurry up", (referring to nurses). They added that often care being delivered, "Feels like going through the motions."
- Patients on ward B6 were overall very positive about the ward and nursing care. They said their care had been personalised, that call bells were responded to quickly. On all wards we observed staff attend to patient in a calm and professional manner.

Understanding and involvement of patients and those close to them

- Staff told us they provided as much information to the patient in advance of them coming into hospital. This included information provision at pre-assessment. Information was further reinforced at admission. Hourly rounds in the admissions lounge unit enabled staff to check if the patient and their relative were comfortable.
- Patients who spoke with us on the surgical admissions lounge told us they had been given information in a way they could understand and that they had been listened to. One patient said to us, "I have been taken through my treatment and have discussed it." Another patient explained how they were given the chance to discuss with the doctor all matters and said, "The doctor explains everything and shows me pictures." Other comments made to us by patients included, "My views are listened to and acted on." And, "any queries I have, the staff will route out the answers and comeback to me."
- All the patients who spoke with us on ward H7 said they felt their treatment had been explained to them and they understood what was happening. In general patients on ward B7 felt they had been kept informed of their progress; however, two patients on this ward said they hadn't been kept up to date with what was happening, such as when they would be going home.
- Patients who spoke with us in the day surgery unit reported they had been given adequate information throughout.
- A patient explained how staff were encouraged to get to know them as patients on the intestinal unit (H8) and that they involved the family. This included open discussions where a person had a terminal condition. The family were said to have bene included in family meetings and the doctor had explained everything, encouraging questions. This patient said they were always told the result of investigations and appreciated the openness of staff.

Emotional support

- Staff told us and we observed that there was access to specialist nurses in areas such as; colorectal, pain management, tissue viability and breast care. The role of the specialist nurses was to be a source of information and support to patients.
- Staff recognised patients who required additional support and provided this. One patient said to us, "I was scared and the staff took time to reassure me, going through the procedure with me." Another patient described the ward (H7) as being, "One happy family." We witnessed positive emotional engagement between a patient who was being discharged, other patients who they had got to know and nursing staff. It was clear that there had been a network of support to this patient.
- On ward B7 some nursing staff were mentioned by name positively in terms of provision of support and overall kindness. One patient told us how the nurse had found a side room so they could have some peace, from what we observed to be a noisy ward.
- One patient who spoke with us had been a patient a number of times said they were hesitant to come in at first but the staff had been, "Brilliant and very patient." They added the staff had a "Technical and holistic approach, not just a medical condition." And, "They talk to me like I am intelligent."
- Pre-assessment staff explained the pathway for women who were to undergo termination of pregnancy. This

included being seen by a counsellor in outpatients following consultation with the doctor. During pre-assessment, women could be referred back to the counsellor if they had any doubts about the procedure or presented with continuing anxiety.

- We reviewed the elective surgery pathway and noted this did not include an assessment of anxiety or depression despite the anaesthetic fitness assessment including psychiatric disease process in the criterions. Whilst there was no formal assessment, the electronic record allowed staff to enter commentary where they had concerns regarding the mental health of patients or wished to add comments which may inform other staff if patients required specific emotional support.
- Ward staff told us patients could access counselling and chaplaincy services if required. Requests were said to be entered on to the electronic patient record and this was then relayed to the relevant staff member.

Are surgery services responsive?

Trust performance with regards to referral to treatment times was generally good. Two specialties were noted to not be meeting national RTT's between April 2013-June 2014; general surgery (88.1% vs 90% national expectation) and trauma and orthopaedics (84.8%). The trust was meeting targets for ear, nose and throat (ENT), (96.1%), urology (93.8%), oral surgery (98.1%) and neurosurgery (92.5%).

Theatre utilisation was identified as being below expected performance which had impacted on the efficiency of patient bookings. The service had undertaken a range of initiatives to improve theatre utilisation and provisional data demonstrated that some progress had been made in this area. Patient flow through the surgical services was limited by availability of beds linked to delayed discharges. This was particularly associated with patients requiring on-going support from areas outside the local region.

The individual care needs of patients were fully considered by staff. There were arrangements in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available and information in alternative languages could be provided on request.

The complaints process was understood by staff and patients were supported to raise concerns. Where complaints were raised, these were investigated and responded to and lessons learned were shared with staff.

Service planning and delivery to meet the needs of local people

- The surgical directorate was divided into two divisions. This enabled the respective services to focus on and deliver the required services to the local population and beyond in accordance with the wider regional structure of speciality surgery.
- We reviewed the 'seasonal surge plan' for dealing with periods of high activity. This included reducing or rescheduling non-urgent elective cases during peak times and included a phased return to normal services when capacity and demand allowed. Winter planning was required to be discussed at the bed capacity meetings and included reviewing activity 24 hours in advance.

Access and flow

- Surgical admissions were based on elective or emergency surgical pathways, the latter usually via the accident and emergency department.
- Patients referred by their GP were seen by the relevant speciality as an outpatient consultation. From this appointment patients were either made an appointment to attend the pre-assessment clinic or had direct access on the same day, via a one-stop process; this reduced the number of visits patients were required to make to the hospital prior to their planned procedure or surgery.
- The pre-assessment clinic was poorly signposted and was not easy to find. This was a nurse led service but also had an anaesthetist led appointment schedule in place Monday to Friday. Patients could be seen directly by the anaesthetist, prior to the nursing staff or be referred to the anaesthetist by nursing staff based on their assessment findings.
- Access to the pre-assessment unit was limited for individuals who used bariatric wheelchairs. These cohorts of patients were assessed in area 4 of the out-patients department where there was suitable access.

Surgery

- Whilst there were no suitable fire exits which could accommodate stretchers within the pre-operative assessment area, the trust had assessed this area and had considered it as "low risk" with ambulant patients only attending the area. Where patients were not ambulant, they were seen and assessed in the out-patient department.
- The level three assessment unit provided eight female and six male beds, with throughput of usually 10-12 patients having injections and three –four elective neurosurgical patients. The department was open Monday to Friday between the hours of 7am and 6pm.
- The day surgical unit had various pathways to support patient treatment and care, such as an emergency abscess pathway and termination of pregnancy pathway.
- Bed capacity meetings took place four times a day, during which hospital activity and flow was reviewed. Staffing meetings took place 6 times per day to ensure that there were sufficient staff to support the wards and theatres.
- Theatre utilisation had been identified by senior managers as sub-optimal; the lowest utilisation was recorded at 65% in July 2014 (the national average in England was 86%). There was variation across surgical specialities from month to month which contributed to this, such as cancellation of sessions and delays in start times and turn around. As a result there had been an increased focus on improving theatre usage with a target for session utilisation set at 92%. We saw results presented to us for October, November and December 2014, indicating theatre end utilisation was at 76.6% and therefore improving.
- We reviewed summarised information by speciality in respect to theatre utilisation which was outlined in the division of surgery directorate report for December 2014. In addition we saw the action that was being taken including the implementation of a theatre scheduling and effective utilisation protocol. This clearly outlined processes and responsibilities in order to improve performance.
- We reviewed data for referral to treatment times for the period April 2013-June 2014. This showed the trust was failing to meet the 90% treatment target for general surgery (88.1%) and trauma and orthopaedics (84.8%). They were meeting targets for ear nose and throat (ENT), (96.1%), urology (93.8%), oral surgery (98.1%) and neurosurgery (92.5%).
- Referral to treatment was said by senior managers in the surgical directorate to be good in general surgery and compliance with this was monitored weekly. The senior managers within the surgical directorate had identified an issue where approximately 350 orthopaedic patients had been inadvertently removed from the referral system and when this was discovered action was taken to rectify the issue in a timely way. At the time of our visit it was stated there were 75 patients still outstanding, 45 of whom had dates for surgery and it was expected dates would be made available by the end of January 2015 for the remaining patients.
- The average length of stay (ALOS) for the period 2013/14 was mainly worse than the England average with all non-elective surgery. Similarly ALOS was higher for elective surgery, trauma and orthopaedics.
- We were advised that an extra spinal list had been added to the schedule on a Thursday to cope with demand.
- Staff described the discharge arrangements to us, which they said commenced as early on a patient's journey as possible. Where required, discharge arrangements would include arranging community nurses and transport. Staff told us there were three discharge co-ordinators.
- We saw there was an early supportive discharge process for fractured neck of femur for local Salford based patients but not the wider referring community. Staff reported that delays in patient discharge tended to be related to the wider community, as it was difficult to arrange on-going support. They added that to their knowledge there had not been any formal discussion with the wider representatives of the community to resolve this.
- A number of patients who spoke with us were aware that staff had been trying to organise rehabilitation or equipment in preparation for their discharge home. There was awareness from patients that these factors could delay their discharge. At least two patients were concerned that they were 'bed-blocking' because of these factors.

Surgery

- We found there were comprehensive discharge instructions provided to day case patients. A discharge letter was given to the patent and this included details of their follow up appointment and when sutures were to be removed. Staff also had a discharge policy to guide them.
- The number of patients who had their surgery cancelled and were not re-booked for surgery within 28 days was better than the England average for the majority of months reviewed across the period April 2011 to April 2014. The surgical directorate report for December 2014 indicated there had been eight breaches of the 28 day target, in the division of surgery.
- We were told there were between five and 10 operation cancellations per week for a variety of reasons, mainly patient clinical condition, no theatre time, lack of equipment or no beds available for post- operative care. However, the surgical directorate report for December indicated that 68 cancellations had occurred in November 2014, a reduction on the previous month's cancellation rates of 77. Lack of theatre time was highlighted as the main reason for cancellation in 16 of the November cases.
- Cancellation meetings, minutes of which we reviewed, had been initiated on a weekly basis and staff said there was an escalation process in place to ensure senior management were aware and agreed to cancellation.
- Number of patients not treated within 28 days of a cancelled procedure was low, with five patients not meeting this target for the period January to June 2014.
- Hip fracture audit information supplied to us indicated that 90.2% of patients with a fractured neck of femur were operated on within 48 hours, which was better than the England average of 87.3%.

Meeting people's individual needs

- We spoke to patients about their experiences of staff meeting their individual needs. The majority provided favourable comments. However, one patient on ward B1 reported having been distressed by the staff's inability to support them to use their own wheel chair. This had been brought in from home a week earlier and they had not as yet been able to use it. They said staff had said they did not have enough staff to help set the wheel chair up. This impacted on this person's independence.
- We observed that arrangements were in place to support patients who had individual needs related to their mental health. This included one to one nursing.
- We were told about and saw an example of a personal passport for a patient who had learning and physical disabilities. The passports were said by staff to be completed by those closest to the patient and provided details about their individual needs, methods of communicating and best manner in which to support them.
- Copies of patient passports were available in other languages, such as Polish and Urdu.
- Within oral surgery there was a designated list for provision of support to individuals undergoing procedures with learning disabilities.
- We heard from ward staff the details about identifying and caring for patients who had a cognitive impairment, such as dementia. There were named champions for dementia care on wards, who were responsible for reinforcing good practice. We saw that patients who needed additional support were identified by a blue butterfly. This was attached to their personal notice board above the bed. They also wore a blue wrist band.
- On ward B6 (Trauma and orthopaedics) we saw the quiet room, which had been set up to support people who may have a cognitive impairment. This had a selection of older pictures on the wall, a memory box and games were available.
- A newer member of the nursing staff said they had received training in relation to dementia and this had helped them understand how to approach, assess and support patients more effectively.
- We saw there was a pathway for referral through pre-assessment, which was called 'Proactive review of older orthopaedic patients undergoing surgery', (POPS). Patients who met certain criteria were booked into the MDTPOPS for a multi-disciplinary review prior to listing for surgery. This enabled staff to identify and respond to specific needs.
- A self-management pathway for patient's using the colorectal service had been implemented which had led to multiple follow ups being prevented and an improved patient experience.

Surgery

- A patient who spoke with us explained how they had direct support from the Parkinson's specialist nurse. Patients also had access to other specialist expertise in order to meet individual needs. We spoke with breast care nurses who described some of the aspects of their role. This included supporting patients with relaxation techniques as well as supporting them in areas including the management of their diet and symptoms of lymphoedema.
- Staff explained that they could organise translation services via telephone. We heard a nurse offering the service of a translator to a patient. However, we noted that the manner in which this was communicated suggested the onus was on the patient to have organised a translator in time for their appointment. The nurse did not demonstrate empathy or respect towards the patient.
- Patients attending the intestinal failure unit were invited to quarterly focus group meetings, where they were able to talk about their experiences. This was seen as a supportive service and valued by staff and patients.
- As a result of feedback from this meeting staff had started to use a bedside note book for patient's to put questions in. The nurses led their own ward round the day after the multi-disciplinary ward round, which we were able to attend. During the nurse ward round they checked patient understanding and answered any questions. Staff entered information into the note book so that the patient could refer to this later.
- Staff told us that female patients were occasionally nursed in side rooms on the male neurosurgical ward, B7. There was only one shower on this ward, which meant female patients had to be taken to the female ward, B8 to use the shower facilities. Wards B7 and B8 were inter-connected and so there was no requirement for women to leave the clinical setting to access the female showers.
- We observed that each patient had an information board above their bed, on which was recorded their named nurse, preferred name by which the patients wished to be referred to as and their particular goals. We were able to question patients about their goals during the nurse led ward round on the Intestinal failure unit. A patient confirmed with us their goal to be pain free had been met, with regular provision of pain relief.
- We saw on all wards that staff ensured privacy curtains were closed around bed areas and bathrooms/toilet doors were locked when in use.
- Website information indicated that staff undertook intentional rounds as follows: Every hour between 8am and 10pm and every two hours between 10pm and 8am. During such rounds staff were expected to check on the following: patient wellbeing, check whether they had any pain, assist to move position if required, check whether they needed help to go for a walk or to the toilet and to ensure patients had access to their bed table, drinks and the nurse call-bell. We saw records made for each patient, which indicated staff had checked on their status at two hourly intervals.
- Patients in pre-assessment said the service had been, "Excellent" and they had not waited too long to be seen.
- We received some negative comments about the food from patients on ward H7, including, "Lots of things come with chips." Another person said, "The food is rubbish, could be better", adding, "Not what I call healthy."
- A patient on ward B7 said their family was bringing in food because the, "Food quality is not good or healthy." Another patient said they also asked family to bring in food to supplement what was provided to them.
- Patients on ward B6 commented negatively on the meals. For example a patient who had been on the ward for almost six months said the menu was repeated on a two week cycle. The nutritional value of meals was thought by some to be poor, such as pie and chips every day.
- The trust provided us with copies of the menus from December 2014; menus were noted to offer patients a choice of meals with both hot and cold options available for both lunch and dinner. A vegan menu was noted as being available and an easy to follow code was available to help patients make appropriate decisions about the food they chose with examples including "low salt", "easy to chew", "high energy" and "renal" diets.
- Within theatres there was a newly provided room for relatives of patients who were emergency admissions. We saw this was a comfortable area with access to refreshments.

- A designated clinical psychologist was available to support patients with psychosexual problems as a result of their complex medical problems on the intestinal unit. Staff were also able to receive clinical support from this member of staff.

Learning from complaints and concerns

- Ward staff were able to describe how they dealt with complaints. This included; listening to the patient, respecting what they said, making a note of the matter and explaining how it would be dealt with. Generally staff said they would pass information to a more senior staff member or to a manager for action.
- The divisional directorate report for theatres dated November 2014 indicated there had been two formal complaints in 2014 and five informal complaints. All but one, for which an investigation remained in progress, had been completed and resolved.
- We spoke with a long-term patient who was on the Intestinal failure unit. They explained how there had been frequent problems with porters availability when they were admitted into other wards. This caused a delay in receiving their nutritional feed and although a meeting was held with portering staff, no solution was ever reached. It was also reported to us that staff on other wards were not being trained with regard to the specialist care needs of patients with intestinal problems, such as feeds and complex stomas or fistula. The problem was said to have been reduced by the appointment of an outreach practitioner although further work was required to ensure that all relevant staff received additional support and education in this area.
- Patients told us they had not felt the need to raise a complaint but if they did, some were aware of the process and others said they would find out. One patient said they were unaware of the Patient Advice and Liaison Service (PALS). We observed information in all areas which advertised details of PALS. Information on making complaints was also available from the trust website.

Are surgery services well-led?

Requires improvement

Senior leaders understood their roles and responsibilities to oversee the standards of service provision in all surgical areas. However, within operating theatres, where there had been considerable change in management in the previous 18 months there were aspects of the service which were not being effectively monitored specifically the reliable monitoring and use of the WHO checklist and reliable fridge temperature and equipment check recording. Further, although senior managers recognised the difficulties of bringing about change in the theatre environment to improve utilisation, there was resistance by a small number of staff and this was impacting on some aspects of the service.

The surgical divisions had a clear direction of focus underpinned by broad strategic aims and principles. There were robust governance arrangements in place to monitor, evaluate and report both upwards to the trust board and downwards to all staff.

The surgical directorate identified actual and potential risks at a service and patient level and had in place mechanisms to manage such risks and monitor progress.

Staff reported positively on the level of engagement with immediate line managers, the communication channels used and general level of support they had. Leadership on surgical wards was said to be effective; this was demonstrated by the fact that ten of twelve surgical wards had attained SCAPE status; this demonstrated that the wards consistently delivered safe, clean and personal care to patients. It was apparent that retention of SCAPE status for the wards was achieved through good clinical and nursing leadership.

There were opportunities for patients, staff and the public to contribute to the running of the service.

The surgical directorate fostered an environment which encouraged innovation, learning and continuous improvement.

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Vision and strategy for this service

- We reviewed the divisional draft annual plan for 2014/15, in which principle and corporate objectives had been set out under a number of themes, such as safety and quality. The plan identified various areas of focus, for example; nurse led discharge and improving availability of specific patient information and the discharge process, reducing inpatient breast surgery rates and increasing outpatient service capacity as well as improving theatre start time and reducing kit wastage.
- The Trust website indicated that the core values were 'Patient and customer focused', based on; continuous improvement, respect and accountability.

Governance, risk management and quality measurement

- The two surgical divisions were overseen by separate designated senior staff, with accountability to the trust board through an executive lead. Two separate board meetings were said to take place each month, one to consider assurance and one in respect to operational matters. Directorate forums were held every two weeks, one of which focused on performance and one on strategy.
- Monthly governance meetings were said to provide an opportunity for each speciality to feed back in turn on the patient experience, clinical outcomes including information on pressure ulcer rates and re-admissions. Trends were fully considered and information from this fed up to the executive governance system through the trust board.
- We reviewed the division of surgery governance minutes for the months of August, September and October 2014. Discussions had taken place around the divisions annual plan including themes from incident analysis, the objectives of the service, required actions to resolve recurring issues and initiatives taking place within the department. Information reviewed included a summary of update on progress and any required actions from existing issues. For example, we saw information discussed around patient enhanced recovery, infection control reports, patient experience and clinical performance. In addition we noted clinical governance leads presented feedback on various matters, including incidents and learning from these, patient complaints and compliance with professional guidance. However, the existing governance arrangements were not suitably robust to ensure that staff were undertaking routine safety checks as we identified within the safety domain of this core service.
- Assurance and risk committee meeting minutes for October and December 2014 were reviewed for neurosurgical theatres. Although the minutes were not sufficiently detailed for non-attendees to know the

depth of discussion, we saw adverse incidents had been discussed. Similarly we saw an infection control update listed but we could not identify what had actually been discussed.

- The divisional risk register for surgery was reviewed by us and was noted to be extensive in the consideration of principle risks linked to the objectives set out in the annual plan. The level of risk was identified (moderate, serious or significant), along with actions described to manage gaps in the controls and assurance, and with associated review dates and executive leads.
- The surgical risk register reflected broader risks and associated actions as set out in the Trust Board Assurance Framework 2014/15. We noted significant serious risks were required to be reported to the Executive Assurance and Risk Committee (EARC). Significant serious incidents to the Trust were to be reported to and managed through the Board of Directors via EARC.
- We found that, in response to serious incidents and in line with the trust-wide risk management strategy, action was routinely taken to address omissions or to review processes. However, it was noted that following a never event in 2013 where a contributing factor to the incident was an omission to either complete or to record a world health organisation five steps to safer surgery checklist, recommendations were made that assurance systems would be introduced to ensure that staff were utilising the WHO checklist appropriately and that the quality of the use of these systems was monitored. We found that auditing of WHO checklists or the five safer steps checklist was not being undertaken as staff were waiting for the WHO checklist to be loaded onto the trust wide electronic patient record system, which in turn would permit senior staff to more easily review and monitor the quality of the process.

Leadership of service

- We spoke with matrons about leadership at surgical department level. Matrons explained how they were available to support staff on a day to day basis. They also ensured engagement with night staff, which included them completing one week of night shifts each month. There was also a corporate matron for nights, providing leadership to the night staff.
- A leadership forum was said to take place, which anyone could attend. Publication of feedback from this was posted on the intranet.
- We found, and the majority of staff reported theatres to be well-led at theatre management level, with the lead nurses making considerable progress. However, it was reported to us that further improvement and change was being hampered by a small number of staff who on occasion, bypassed the theatre lead nurse and sought support and intervention from the clinical director.
- With regard to theatres we also found decisions about business efficiency, theatre staff culture and practice were being made at a strategic level, rather than by the immediate management team.
- Focus group discussion with theatre staff indicated general upset with regard to the changes to the operating schedule. Comments made included lack of consultation around the moves between business units and lack of support from band seven staff and above.
- Ward staff spoke positively about their local departmental leadership, with comments such as, “Very communicative and approachable.” One member of staff said, “I can express my feelings.” They added that team work was what mattered and they felt they were doing well on the ward.
- Another staff member commented on the level of communication, telling us there were regular team meetings and newsletters as well as receiving information via email.
- Senior nursing staff explained that there was a clinical walkabout by the executive team on a monthly basis, which they could join for their own development. They also told us about senior team members spending time working alongside other staff periodically. Some nursing staff were aware of the more senior leaders doing the latter but others not so. The Chief Executive Officer (CEO), although known by name, was not necessarily seen by staff. One nurse who had worked for 11 years at the trust said they had never met the CEO, although they knew his name.
- We were told that the recent movement of speciality surgery across the two levels had not included management for the respective teams. This had resulted in managers from level one managing theatres and the

staff on level three and visa-versa. Staff raised concerns about teams being isolated, working in a different department to colleagues and also the lack of flexibility for sharing staff at busy times.

Culture within the service

- Ward staff talked to us about the values they applied to their roles, for example; the patient being their priority, being there for the patient and providing safe, high quality care. Although some staff felt it could be pressurised at times, they understood and accepted the philosophy of providing high standards and "Being the best."
- Staff felt it was an open and learning culture in general and they were or would be listened to by senior staff. The majority of staff we spoke with were very happy in their roles. There was a feeling expressed by a few staff that there was over auditing and some activities took away time from them being able to provide patient care. A member of staff said, ''I take pride in my holistic approach" to patients.
- Staff told us there was a good working relationship with colleagues, including consultants, although some were more approachable than others.
- Student nurses told us that they enjoyed their experience and the learning opportunities at the trust. They felt supported and whilst they were not included in staffing numbers, they enjoyed having the opportunity to be 'hands on' and being able to develop their skills.
- Our observations and discussions with patients provided further insight into the culture of the service. We found it was a proactive culture in general, with a clear focus on delivering high quality care, safely and as efficiently as possible.
- An update to the executive quality and safety committee dated 5 March 2015, of which a copy was provided to us on 6 March, indicated that theatre staff had been invited to attend a range of engagement events towards the end of 2014 and that, in response to the feedback from staff a revised Theatre Improvement Programme had been developed which was based upon the NHS Institute for Innovation and Improvement Productive Operating Theatre Programme. This initiative commenced within general surgery and neurosurgery in February 2015 and so it was not possible for us to measure the effectiveness of the programme.

Public and staff engagement

- A patient, who had been using the intestinal failure unit over a long period of time could not speak more highly of the staff and ward itself. They said they had been involved in designing the ward when it was being built. There was regular, quarterly engagement with staff in the form of a focus group on this ward and information was used to improve patient experiences. For example, a welcome pack had been developed for patients. This included information to help them be safe around pressure ulcer avoidance, the four 'P's: Pain, Personal care, Position and Possessions. A diary was included, which could be taken out or used to support questions or discussion around problems they experienced.
- We reviewed staff surveys for the Neurosciences and renal services, which had been carried out in May 2014. We saw high satisfaction scores for: support from work colleagues, levels of responsibility given to staff, support from immediate managers, opportunities to use skills and managers taking a positive interest in health and well-being. The latter echoed information supplied by staff, who described managers being flexible on their return to work following personal circumstances.
- Less positive scores were achieved in the survey in respect to communication between managers and staff, lack of involvement of staff by managers in decision making, the appraisal process and feeling valued. We noted that components of the survey relating to bullying and harassment also indicated improvements were required.
- A 'Glimpse of brilliance' noticeboard had been introduced in theatres. This was said to be used for identifying good ideas and practice. There was a learning board to support actions and outcomes. Both boards had been populated with information; however, staff said they were not used by them very much.
- Staff in theatres were fairly vocal about the changes in the service, such as being affected by longer working hours as a result of spinal surgery sessions running later into the evening.

Innovation, improvement and sustainability

- We were told about the various collaborative programmes taking place across the surgical division. We noted from the minutes of the Quality and Safety – Executive Governance Committee minutes for January

2014 an update on progress in respect to the pressure ulcer collaborative had been given by the Neurosurgery theatre. This identified actions taken and further recommendations, including additional retrospective studies of all patients operated on in the prone position as a means of improving patient safety for future cases.

- Staff were encouraged to undertake research, for example, we reviewed a paper published in respect to improving patient care in a national intestinal failure unit.
- The surgical division celebrated the positive arrangement they had for the movement of elective orthopaedic work off site and anticipated this would improve patient throughput, standardise use of prosthetics and develop a centre of excellence.
- The surgical division indicated they had established a link with Central Manchester NHS Foundation Trust, which they anticipated could lead to future partnership working in their developed Manchester Orthopaedic Centre. This was expected to lead to increased pooled volumes of specialist activity with standardised practice leading to improved patient outcomes.
- The surgical division annual plan described the development of a service model for emergency and complex surgery with two other NHS providers.
- We saw in the theatre staff newsletter produced for December 2014 an introduction to the forthcoming 'Theatre Improvement Programme'. We were told this was due to commence at the end of January 2015, with the aim of ensuring theatres could provide safe and reliable care, provide value and efficiency and deliver a high team performance with high team morale and well-being. This work was being co-ordinated and delivered through a Quality Improvement methodology, led by a steering group headed by the Director of Organisational Development and Corporate Affairs. We saw from information provided to us that the programme was based around the Productive Operating Theatre model, developed by the NHS Institute for Innovation and Improvement.
- The senior managers within the surgical directorate recognised the areas for further focus, which included interventional radiography, middle grade recruitment to medical staff, the delivery of complex emergency care and making improvements to the discharge process, by reviewing and enhancing the patient pathway.

Critical care

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

Information about the service

The Trust provided a service to patients who required advanced care in a purpose-built, 38 bedded critical care unit (CCU). The unit included two high dependency units (HDU) which delivered specialist surgical and neurological advanced care. The Trust also provided advanced medical care in a HDU on the first floor. Whilst the nursing team for the medical HDU had been amalgamated with the critical care unit (CCU), clinical management and oversight was provided by a team of medical physicians.

50% of the total number of critical care beds were single side rooms which meant the unit had sufficient capacity to isolate patients who had acquired infectious diseases as well as ensuring single sex accommodation. The unit facilitated approximately 600 admissions every quarter with the majority of patients receiving level one and two care.

At the time of the inspection the hospital was experiencing unprecedented pressure on the service which reflected themes and trends nationally.

We talked with 7 patients, 55 staff and 20 relatives during the process. We visited the critical care unit, the surgical and medical high dependency unit (HDU). It is worth noting that the inspection took place during a period of unprecedented demand on the service which presented some difficulties to ensure we balanced the needs of the inspection with the numbers of staff we could talk with, without interrupting the delivery of care.

Summary of findings

We found some disparities in the way that patients had their mental capacity assessed and managed. Records we viewed demonstrated a variance in practice throughout the unit. Some patients had received appropriate mental capacity assessments and had gone on to have the appropriate deprivation of liberty safeguard (DoLS) (deprivation of Liberty) assessment in place.

At the point of admission to the critical care unit, staff carried out a total of 6 risk assessments within the first twenty four hours; two assessments were undertaken in within the initial 2 hours of admission. We were told that a total of seventy four risk assessments were completed within seventy-two hours of admission and that staff received an email reminder to ensure the process was completed. However, when we looked at specific records we found disparities in the information recorded.

The nursing and medical staff were very focused on delivering care as per the trust's ethos and wanted to deliver the best care possible. Documentation targets were continuously met but the quality and consistency of the information recorded did not always reflect the status of the patient. The EPR system was fully integrated however the unit still utilised a paper based clinical observation document. Whilst paper records

were kept secure, in one instance, where we asked to review a Deprivation of Liberty Safeguard application, it took staff a significant period of time to locate the document.

The Intensive Care National Audit and Research Centre data (ICNARC) indicated some concerns regarding delayed discharges, out of hours' discharges and late re-admissions on the unit.

Incidents were reported and acted upon and used continuously as a service improvement tool. Safety thermometer data was collected and displayed in public areas for patients and relatives to view. All the areas we viewed were visibly clean and tidy and staff were observed adhering to infection control policies. Staff reported having an adequate supply of equipment to meet people's needs and we saw documentary evidence that equipment was regularly serviced.

We found appropriate measures in place to ensure the safe administration, storage and disposal of medication. There was an adequate number of nursing and medical staff to provide a seven day service and an appropriate major incident policy was in place.

The unit participated in local and national audits and had employed three staff whose sole purpose was data collection. Unit policies reflected national and best practice guidance and we found that the care being delivered was evidence based.

There was a great emphasis put on an MDT (Multidisciplinary Team) approach to the delivery of care. Staff were subject to a hospital induction as well as a local induction to the clinical area. They were provided with a mentor, annual appraisal and supervision sessions.

The dignity of patients was maintained at all times; staff were observed to be conscientious to ensure patients were appropriately covered at all times. The staff interactions with patients and their relatives were observed to be kind and compassionate. Relatives we talked with were very complimentary about the staff, and the service their loved one received. The unit provided adequate emotional support for patients by referring to the hospital psychological service, using clinical nurse specialists and the chaplaincy. Patient survey data demonstrated that 90% of those surveyed would recommend the unit.

The service was found to be responsive to patient's needs and took account of complaints and suggestions made. The service was a leader in providing a comprehensive follow-up service to patients who had received critical care treatment lasting five or more days. Staff working on the critical care unit engaged at a national level in the development of NICE guidance in relation to critical care rehabilitation. The critical care patient experience and follow-up service has been recognised nationally and has been nominated twice for national nursing times awards.

Staff had confidence in the way incidents were reported, investigated and learned from. Staff reported feeling very involved in the governance process, risk management and quality improvement not only from a departmental perspective, but from a trust perspective. Meetings were minuted and had clear actions plans that presented a thorough audit trail.

There was an important emphasis toward ensuring that both staff and the public were engaged in how the unit was managed and run. Staff told us they felt valued, were consulted continuously, and were proud to be able to influence organisational change. Members of the public were able to engage with the trust by leaving feedback from their experiences, either formally or through social medial. We noted several suggestion boxes in the appropriate areas and posters encouraging posters around the unit. The people we spoke to said they felt very confident they could raise concerns or make suggestions.

Critical care

Are critical care services safe?

Good

At the point of admission to the critical care unit, staff carried out a total of 6 risk assessments within the first twenty four hours; two assessments were undertaken in within the initial 2 hours of admission. Staff told us that patients had a total of 74 risk assessments completed within a seventy two hour period and that an email reminder was sent to ensure the process had been completed. However, when we looked at specific records we found disparities in the information recorded. We were unable to identify a process of auditing the quality of what was recorded in these assessments.

There were systems in place to ensure learning from adverse incidents, errors and near misses which ensured the risk of recurrence was minimised; incidents were considered at multi-disciplinary team meetings to ensure learning was disseminated across all professional groups.

We found suitable infection control procedures in place which ensured patients were protected from the risk of health acquired infections during their hospital admission. Medications were stored and handled safely and medication errors were continuously monitored and acted upon.

There was an adequate supply of equipment to meet peoples care needs. Records demonstrated that equipment was fit for purpose, properly maintained and was used correctly and safely by staff who received competency based equipment training.

Patients who used the service had their care needs met by sufficient numbers of appropriately trained staff. Staff received a comprehensive unit induction and had the necessary support to provide care and treatment. Documents and conversations demonstrated an induction process for temporary workers.

There were appropriate arrangements in place to deal with foreseeable emergencies and staff were aware of the expectations placed upon them should an emergency arise.

Incidents

- Data from the national learning and reporting system between August 2013 and August 2014 indicated that no incidents resulting in serious harm associated with critical care services had been reported.
- The trust used an electronic incident reporting system to record and monitor events.
- Incident reports were reviewed as part of the quality and governance process.
- Staff reported feeling empowered to report incidents. Lessons learnt from these events were regularly communicated through handovers and staff meetings and email.
- We reviewed documentary evidence of regular and detailed mortality and morbidity meetings. These meetings had a multidisciplinary approach and frequently incorporated peer review from other specialities, for example surgery, medicine and neurology. Events discussed at these meetings were escalated to the governance board when appropriate to do so. Actions from these meetings were clearly documented and acted upon in a timely manner.

Nursing Assessment and Accreditation System (NAAS) & Safe, Clean and Personal Care Every Time (SCAPE)

- The critical care department participated in the trust wide Nursing Assessment and Accreditation System (NAAS). This is a performance assessment framework based on the trust's Safe, Clean and Personal approach to service delivery and incorporates the Essence of Care standards, key clinical indicators; each question is linked to Compassionate Care (the 6cs – care, compassion, competence, communication, courage and commitment). The framework was based around 13 standards with each standard further sub-divided into Environment, Care and Leadership'. The NAAS was designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements were required. The assessment was carried out on an unannounced basis and involved observation of care and documentation and discussion with staff and patients. Following the review the area being inspected is accredited with a rating which equates to their performance scores and determines their re-inspection frequency. Action plans were required for any shortfalls and these were time bound and monitored by the management team and

also reported to the trust board. As of January 2015, the intensive care unit, surgical high dependency and medical high dependency had each attained SCAPE (blue) status, the highest rating possible. SCAPE accreditation (blue) was deemed to be the optimum achievable score.

Safety thermometer

- Safety thermometer data was collected and displayed in public areas for patients and their relatives.
- The data submitted to CQC collaborated with the data displayed in the unit and demonstrated consistent harm free care.
- Data submitted by the trust indicated that following the introduction of a pressure ulcer collaborative in 2011, the number of pressure ulcers attributed to critical care had reduced from 37 in 2011 to 2 in 2014 with the last grade 3 or 4 ulcer being reported in November 2011.
- Two falls were reported on the safety thermometer for the twelve month period. A total of 9 incidents relating to slips, trips or falls were logged on the incident reporting system for surgical HDU (3 incidents), Neurological HDU (2 incidents) and the Medical HDU (4 incidents) between June 2014 and November 2014.

Cleanliness, infection control and hygiene

- We visited a range of areas including pubic areas and facilities, storage areas, sluices and relative's rooms. The majority of the areas were found to be cleaned to a very high standard.
- Cleaning logs and records of curtain changes were available for review.
- Legionnaire bacteria testing was completed regularly by the facilities department and the housekeeping staff ensured that shower heads were flushed regularly therefore minimising the risk of legionnaire bacteria colonisation within the department.
- We reviewed other areas including the blood gas analyser room and administration station and found them to be visibly clean and tidy.
- Hand gel dispensers were available through the unit.
- Data suggested the units' MRSA rates were within the national average and C.diff rates were better than the England average. Through the use of quality improvement methodology, the trust have reported a 79% reduction of MRSA colonisation within the critical care setting.
- 50% of the beds on the unit were side rooms, which meant that patients who had acquired an infection could be isolated if required.
- The unit had three microbiology ward rounds a week to monitor antibiotic usage and to provide support and advice for patients and their medical teams.
- The infection control policies reflected national guidance.
- Staff were observed adhering to the trust infection control policy and were seen to use appropriate personal protective equipment (PPE) when delivering personal care.
- We noted an ample supply of PPE was available in the clinical areas.
- Sharps bins were labelled, dated and not exceeding the recommended capacity.
- We observed that the administration staff routinely asked visitors to wash their hands on the way into the unit.

Environment and equipment

- We reviewed the resuscitation equipment in all the areas we visited. The check list we viewed demonstrated that the relevant checks were routinely carried out.
- We noted that each emergency trolley had a folder with pictorial descriptions of each item required as well as information for staff on how to source replacement items. This was considered best practice and ensured new staff or locum staff were aware of the contents in an emergency and for restocking purposes.

Medicines

- We found that the department had appropriate systems to ensure that medicines were handled safely and stored securely.
- There was a system to ensure that medications that were no longer required were safely returned to the pharmacy department.
- The unit had a daily pharmacy round which ensured medication stock was readily available and that medication audits were undertaken.
- The controlled registers were completed and checked as per hospital policy. However we noted a small number of gaps within the stock audit log which was attributed to the controlled drug stock held within the Surgical High Dependency Unit (SHDU).

- We carried out random controlled drug checks which demonstrated that actual stock matched the stock accounted for in the registers.
- Staff had undertaken competency based medication training which was reviewed annually or immediately if a drug error was identified.
- The people we spoke to told us that they received their medication at the times they needed them and in a safe way.

Records

- The Trust used Electronic Patient Records (EPR).
- At the point of admission to the critical care unit, staff carried out a total of 6 risk assessments within the first twenty four hours; two assessments were undertaken in within the initial 2 hours of admission. Patients had a total of 74 risk assessments completed within a seventy two hour period. Staff told us that they received an email notification if the assessments were not completed within the required timeframe.
- We found that the service was still reliant on a small proportion of paper records. This was especially applicable for patients who were subject to an authorised deprivation of liberty order; DoLS applications were a multi-agency, paper based document and as such could not be incorporated into the EPR.
- During the inspection, one patient was subject to a DoLS order and when we asked staff to provide this, there was confusion as to whether the order was paper based or electronic. It took staff a significant period of time to locate the document.
- Where paper records were being used, we found that these were stored in a secure place.

Safeguarding

- The trust had an appropriate safeguarding policy that reflected national guidance.
- Staff were aware of the safeguarding procedures and could verbalise the processes used to escalate a concern.
- We found evidence that one patient on the unit, who was identified as vulnerable, had had a multidisciplinary best interest meeting to plan their care and treatment.
- 100% of medical staff and clerical administrative staff working on Intensive care had completed training in safeguarding vulnerable adults. 98% and 97% of nursing staff working in intensive care or on neurosurgery HDU respectively had completed safeguarding vulnerable adult training against the trust target of 95%.

Mandatory training

- The trust operated a strict mandatory training policy that meant staff who were not 100% compliant with their mandatory training were subject to a financial penalty.
- The CCU reported 97.1% compliance with mandatory training. During the inspection we identified the compliance rate as 95%. This met the trust target of 95%.
- The 5% staff who had not undertaken their mandatory training were noted as being exempt due to being on maternity or long term sick leave.

Assessing and responding to patient risk

- The trust used a scoring system (Salford National Early Warning System) to identify patients who may be at risk of their condition deteriorating.
- The unit had a low threshold for admissions to the unit which meant that patients received a higher level of care without experiencing long delays in ward areas. Quarter 3 2014 case mix programme data (ICNARC CMP) demonstrates that patients admitted to the unit with severe sepsis are the lowest in the CMP set. Admission severity scores were also low from all admission sources indicating appropriate recognition and escalation of care.
- Whilst the critical care service did not provide an outreach service, work had been undertaken to up-skill ward staff to recognise and to care for an acutely unwell patient on the ward. The 'Care of the acutely unwell adult – change package' had resulted in a reduction of 59% of patients experiencing cardiac arrests whilst on the ward (per 1000 admissions). Prior to the collaborative (2007), the trust saw on average 11.25 ward-based cardiac arrests per month; this had reduced to an average of 5.8 ward-based cardiac arrests in 2014.
- During our inspection we observed a patient receive a consultant review, diagnostic blood tests and an x-ray

within an hour of a nurse raising her concerns. This demonstrated that the patient had their healthcare needs risks assessed and responded to in a timely manner.

- Staff told us that they felt supported when they raised a concern about a patient's condition and were supported by medical teams in a timely manner.
- Staff told us about 'intentional rounding' which was a way of assessing and reviewing patient's conditions every hour. This was another mechanism to ensure patients were reviewed regularly and received a prompt response when their condition changed.
- We found evidence that venous thromboembolism (VTE) assessments were carried out and we found that there were appropriate prophylaxis in place including anti-embolism (T.E.D) stockings and pharmacological VTE prophylaxis. There had been no VTE's reported within the critical care team within the previous 12 months.

Nursing staffing

- Staffing levels were monitored regularly with an appropriate staffing tool and we found adequate staffing to meet peoples care needs and which were in-line with national standards.
- The department had 195 whole time equivalent nurses in post as of September 2014.
- Existing arrangements meant that at night, one senior member of staff co-ordinated the whole of the critical care floor with the exception of MHDU. Staff told us they would like the trust to implement a unit co-ordinator for the high dependency units at night time as the number of patients and their acuity remained unchanged. We were told that this suggestion had been escalated to the trust executive team for a response.
- A review of publically available trust data demonstrated that the MHDU, NHDU and SHDU, over a three month period, reported no red risks with regards to staffing ratio's for registered nurses or care support workers. We noted that where registered nurse staffing levels fell into the amber zone (less than 95%), additional care support staff were allocated to support the unit.
- We attended three nursing handovers during the inspection. We also participated in a safety huddle. Safety huddles allowed a period of time for patient specific information to be handed over to the nursing team after a bed-side handover had also taken place. We found the handovers and the safety huddle demonstrated effective communication with a standardised approach.
- Staffing rotas were devised electronically. Staff reported feeling confident and competent using this tool to devise rosters. However, we noted that it did not take the individual skill mix and staff experience into consideration.
- We found the skill mix at the time of the inspection to be sufficient. The unit had identified a concern with nursing skill mix and had developed a nurse rotation programme to ensure that all staff had the necessary skills to work in all areas of the unit.
- Band five & six nurses who were unable to develop their management skills on the CCU were supported to move to the high dependency units to do so. This meant that staff could continue their professional progression in the unit which aided staff retention.
- The unit rarely used agency staff to fill nursing vacancies, choosing to use its own staff in the first instance.
- On the rare occasions where vacancies remained unfilled the unit relied on NHS Professionals for temporary staff. Where possible, the same temporary staff were used to ensure continuity of care. We talked with a temporary staff member who confirmed they received an induction to the unit. We checked unit records which demonstrated that all temporary staff had received an induction. Temporary staff were offered a refresher induction every 3 months.
- The unit had employed two advanced nurse practitioners to provide advanced support and care to patients and staff. This role was designed to make a significant contribution to the care and management of critically ill patients and their families, as well as offering structured clinical career progression for appropriate members of the critical care team.
- It was common practice for the unit to 'over recruit' to a 'talent pool' which meant that suitable candidates were already interviewed and put on standby for a post on the unit once it had become vacant.

Critical care

- The unit employed three administrators to support the unit. This number of administrative staff was sufficient to meet the demands of the unit. Additionally, 1 WTE band 6 and 1 band 5 were available to support the service during time of annual leave and unplanned absence.

Medical staffing

- We found appropriate medical cover out of hours on the critical care unit.
- The unit had 30 whole time equivalent clinical staff in post as of September 2014.
- Consultant to patient ratio was found to be sufficient and meeting national standards.
- The unit was covered by three senior trainee doctors out of hours who were supported by an on call consultant. We were told that these doctors were frequently requested to provide assistance to other departments overnight, especially medicine; this was in line with the local trust response protocol for the patient who had been recognised as being acutely unwell at ward level.
- We attended a medical handover and found it to be fit for purpose with good structure and communication within the team.
- The unit preferred not to use locums to cover the unit. The consultants and junior doctors worked flexibly to ensure there were rarely any unfilled vacancies.
- We noted that whilst the consultant team and junior doctors were committed to providing consistent cover to the unit, there was a concern that, from our discussions with the medical team, that they were in the early stages of fatigue which presented a potential risk with regards to sustainability in the future. It is important to note that the results from the staff satisfaction survey report that overall, the levels of pressure felt by staff was lower than (better than) the national average.
- The trust reported that the staffing rota's were in line with European working time directives.

Major incident awareness and training

- The trust had an appropriate major incident policy and procedure and business continuity plan in place.
- The major incident procedure was last tested in 2011 and deemed robust.
- Staff were aware of what the expectations upon them in the event of a major incident.

Are critical care services effective?

Good

There was evidence that patients whom staff identified as having a cognitive impairment were not always subjected to a mental capacity assessment.

Polices and guidance for staff mirrored national guidance. Regular participation in local and national audits ensured that the quality of service delivered was continuously measured and acted upon. We found evidence that data collected was used as a service improvement tool in the department.

The service used appropriate pain assessment tools and we found patient's pain needs were met.

Patients had their nutritional and hydration needs assessed on admission.

The data we reviewed demonstrated good clinical outcomes for the patients who used the service.

All staff had annual appraisals and supervisions. Staff were subject to an in-depth induction period of 6 weeks regardless of past employment experience and were allocated a mentor to aid the learning process.

Staff were expected to undertake numerous competency based assessments to ensure they had the skill necessary to work in the unit.

The service strived to ensure care had a multidisciplinary focus. We observed a range of allied health professionals being involved in care deliver during our inspections. There was ample evidence in people's care notes and from our observations that evidenced a multidisciplinary presence on the unit.

The unit provided a good quality service seven days a week. There was appropriate medical cover and allied professional cover to ensure that patients' needs could be continuously met.

Critical care

Evidence-based care and treatment

- Policies and guidelines reflected NICE, Faculty of Intensive Care Medicine and the Royal Colleges; care was being delivered in-line with NCEPOD (National Confidential Enquiry into Patient Outcome and Death) and Royal College of Surgeons guidelines.
- The unit demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes for patients could be benchmarked against similar units nationally.
- We saw evidence that the effectiveness of the care delivered was continuously monitored to determine quality and compliance with national guidance. For example, patients had their physiological observations, Salford NEWS and interventions from elevated NEWS regularly reviewed.
- The unit provided weekly pre-assessment clinics which enabled staff to assess patients prior to surgery. This ensured that patients with co-morbidities requiring post-operative level 2 or 3 intensive care were identified and had care delivered, both pre and post operatively which met their individual needs. This also ensured that the unit had prior knowledge of the patient and their anticipated admission.
- Staff told us that elective surgery was rarely cancelled due to a lack of availability of critical care beds. This was evidence by the data we reviewed.
- The unit had implemented the use of capnography for all ventilated patients; this was consistent with the recommendations of the Intensive Care Society (Capnography guidelines 2014).
- We found appropriate protocols in place for subarachnoid haemorrhage & traumatic brain injury management.
- Chest lavage was undertaken on admission which helped aid the diagnosis of lung disease.
- The department had implemented a junior doctor audit programme. This aided their personal development and was used as a quality improvement tool.

Pain relief

- We found an appropriate pain scoring tool in use and the patients and relatives we spoke with, told us their pain needs was being met.
- The medication charts we viewed demonstrated that pain relief was administered in a timely manner.
- There was a dedicated specialist pain team in the trust who provided patients and staff with support.

Nutrition and hydration

- We found patients nutritional and hydration needs were risk assessed and acted upon.
- We found documentary evidence that demonstrated a multi-disciplinary approach to meeting patients' nutritional and hydration needs.
- The health records we viewed demonstrated that fluid and nutritional intake was clearly and continuously documented.
- Records demonstrated that patients received consistent input from Dieticians and Speech and Language Therapists (SaLT).
- Patients who required assistance to eat were supported appropriately by staff to do so.

Patient outcomes

- At our last inspection we had highlighted a delay in data submissions to the ICNARC (Intensive Care National Audit and Research Centre). ICNARC helps critically ill patients by providing information/feedback about the quality of care to those who work in critical care settings. We noted that the delay in data submissions had been resolved. This meant that the care delivered and mortality outcomes for patients could be benchmarked against similar units nationally. We noted that the data collected had recently incorporated data/ outcome from the MHDU.
- There was evidence that the unit participated and contributed to research programmes and audits outside of mandatory submissions.
- The unit had employed three staff solely for the purpose of data collection. This ensured continuous data collected and participation in local and national audit programmes.

Critical care

- The unit provided data for Dr Foster intelligence monitoring. Data collected demonstrated low mortality rates for the unit.
- We noted the hospital did not participate in the National Cardiac Arrest Audit. However, after committee discussion it was agreed that the trust had developed a robust system where all cardiac arrests that took place within the hospital were reviewed using a standardised template to extrapolate any lessons learnt or areas to improve future practice. The trust considered that the dataset from the NCAA did not provide them with any additional information that they could not receive from alternative sources.
- Documentation reviewed demonstrated that the unit rarely transferred patients out of the department to another hospital (0.02% of all admissions to critical care).
- Benchmarked quality indications were reported as being low which demonstrates good outcome for patients.
- Local monitoring suggested that admissions requiring support for pneumonia and severe sepsis and requiring ventilation to be within the England average.
- Mortality rates for the critical care unit was lower (better) than the England average. The mortality rates for trauma patients were within the England average.
- The unit facilitated approximately 600 admissions a month. The vast majority of these patients were elective and emergency surgical patients.
- Evidence suggested low mortality rates for planned and unplanned surgical patients.
- Approximately 70% of patients admitted to the CCU required level 3 care on admission.

Competent staff

- The trust had ensured staff working in the critical care had received competency based assessments to ensure they had the necessary skills to do their jobs.
- New nursing staff undertook a six week competency based induction programme and allocated a mentor for support.
- The unit demonstrated a high level of compliance with staff appraisals and supervisions.
- Consultants were subject to a revalidation process which included a 360 degree appraisal.
- Over 50% of the nursing staff employed on the unit held a post registration award in Critical Care nursing. This was in line with recommendations from the Intensive Care Society.
- Nursing staff were rotated through the various specialities in critical care unit to ensure staff had appropriate clinical skills to work in any of the clinical areas.
- In order to support band 5 and 6 staff who were employed on the critical care unit to develop their managerial knowledge and skill set, a range of initiatives were available to support staff to enable them to progress to a higher band. Therefore, in conjunction with individual development plans, staff were encouraged to rotate into other areas in the high dependency unit to facilitate the development of their management skills necessary for career progression. This meant that staff were retained, invested in and eventually promoted rather than leaving the trust to aid personal progression.
- All new staff regardless of designation received a formal induction and were allocated a mentor. The medical and nursing staff we talked with during the inspection were very complimentary about their initial induction and the continued support they receive whilst working on the unit.

Multidisciplinary working

- There was evidence of a multidisciplinary approach to the care that was delivered within critical care.
- We reviewed patient's records which demonstrated that there had been engagement with a range of health care professionals; we observed multiple entries where patients had been reviewed by SALT (Speech and Language Therapists), Dieticians and Physiotherapists
- We observed that representatives from each of these professions attended MDT meetings, accompanying ward rounds and carrying out their daily rounds and providing support for unit staff.

- We noted that physiotherapists were heavily involved in the respiratory weaning process.
- We also noted patient rehabilitation assessments and treatment plans lead by the physiotherapists in the unit. This meant that patients had their rehabilitation needs assessed and planned to promote a timely recovery.
- The discharge process in the unit was found to be in line with national guidance with regards to ensuring patients received 'step down' high dependency care following discharge from level 2 or 3 intensive care. This meant that patients in the CCU were discharged to the relevant HDU and then a ward area.
- The unit did not have an outreach team. The staff and managers we spoke to were satisfied that this decision was evidence based and that the hospital currently did not need one.
- All patients who had remained on intensive care for 5 days or more were followed up by a member of the nursing team once they had been discharged to a ward setting. This was to ensure that the patient had remained stable following their discharge from the CCU.
- Patients could also be referred for follow-up (or further visits) if needed via the electronic referral system once they had been discharged from CCU.

Seven-day services

- We found that allied health care professionals (AHPs) supported the CCU seven days a week. When seven day services were initially agreed by the trust, AHP's opted to provide the extra sessions as over time. However, since commencing this service, the demand and capacity for the service has changed significantly. Staff reported feeling 'tired' and told us they hoped for a service review to ensure a more robust and effective way of providing this level of cover.

Consent and Mental Capacity Act

- We observed saw evidence of very good practice and equally, evidence of inadequate practice with regards to the assessment of people's mental capacity. The records we viewed demonstrated that patients, who were identified as lacking capacity, often had contradictory information recorded. We also noted that where individuals had been identified as possibly having fluctuating capacity, information was not always acted upon as expected with a mental capacity assessment.

Are critical care services caring?

Good

We observed staff interacting with patients and their relatives and found these interactions to be caring and compassionate. The relatives we talked were very satisfied with the level of care their loved one received and the way they were personally treated. Relatives also reported feeling involved in the care, treatment and choices that was available.

There were systems in place to measure patient satisfaction. The data we reviewed demonstrated that 90% of patients would recommend the unit to others.

We overheard a member of staff proving emotional support to a relative in the waiting room. This integration was perceived as being very tactful, respectful and supportive. It demonstrated the caring and professional relationships staff developed with relatives to provide emotional support.

Patients' emotional needs were met by the nursing teams in the first instance. The Trust also provided psychologist services and bereavement services. Staff also told us that they also utilised the chaplaincy service to provide a level of emotional care to patients and their loved ones. Staff demonstrated that they occasionally made referrals to the A&E mental health crisis team who also provided support.

The patients we talked with were very complimentary about the care they received and with how staff interacted with them. One patient told us "I think the staff are fantastic, they work hard" and another commented, "I've no complaints, I'm always treated with respect".

Compassionate care

- We observed staff interactions with patients and found them to be caring and personalised interactions.
- We found patients were well presented and their dignity protected in an appropriate way.
- Friends and Family test results for December 2014 demonstrated that twenty of the eligible 57 people (37%) responded to the survey. 90% of respondents said they would recommend the unit to others.

- The unit had a clinical lead and intensive care patient experience and follow up practitioner for the patient, family and carer experience. A collaborative approach was set up to drive improvements as a result of the feedback received.
- Memories and recollections were sought from patients at follow ups and collated into a list which was available from the follow up team for staff to gain insight into patient experience of the intensive care unit. A decision had been made by the unit not to use patient diaries.

Understanding and involvement of patients and those close to them

- Each bed space in the unit had a dry wipe board that was updated daily. This board recorded personal information about the patients preferred name and listed their personal preferences.
- The relatives we talked with told us they felt well informed and involved in their loved one care.
- They also told us they felt were involved in the planning of care and were kept up to date on any changes to their loved ones conditions. Electronic records also evidenced this involvement.

Emotional support

- The trust employed clinical nurse specialists from various specialities who provided condition specific advice and emotional support for patients and their families.
- All the patients with an intensive care unit stay of 5 days or more routinely receive a nurse-led follow up visit whilst still an in-patient.
- The unit also ran two clinics a month to provide extra support to discharged patients.
- Patients had their psychological needs assessed and acted upon; staff and patients could access the skills of a qualified psychologist so as to ensure that their psychological needs could be met and to receive support where necessary.
- There was a trust wide bereavement service available which was utilised. Staff told us they felt the bereavement service was 'exceptional' at proving support. These services have been discussed in more detail within the 'End of Life Care' section of this report.
- On the CCU, we were told that patients who recovered and were discharged from the unit were followed up in 3 months by the Consultant, nurse and psychologists to provide support if required.

Are critical care services responsive?

Outstanding ☆

Whilst the data we reviewed demonstrated that patients were likely to experience some delay in being discharged from the unit due to a lack of bed availability on wards and other clinical areas, flow into the critical care unit was well managed; the frequency with which elective procedures were cancelled as result of a lack of a critical care bed was extremely low as was the number of patients transferred out of the unit for non-clinical reasons.

The care delivered was patient centred and considered all aspects of an individual's circumstances. The service made reasonable adjustments to reflect patient's needs, values and diversity. We observed good communication between staff and their relatives and could see from the EPR notes that patients were adequately supported to make decisions about care and treatment.

The service was a leader in providing a comprehensive follow-up service to patients who had received critical care treatment lasting five or more days. Staff working on the critical care unit engaged at a national level in the development of NICE guidance in relation to critical care rehabilitation. The critical care patient experience and follow-up service has been recognised nationally and has been nominated twice for national nursing times awards.

We found evidence that the service actively encouraged the views of patients and their relatives. The service had systems to deal with comments and complaints and included providing patients who use the service with information about that system.

Patients could be assured that their comments and complaints were listened to and acted on effectively.

Critical care

Service planning and delivery to meet the needs of local people

- Care was delivered in a combination of an open ward and side rooms. We found evidence that best practice in relation to single sex accommodation was continuously adhered to.
- Staff were actively encouraged and supported to become multi-skilled. This ensured that the unit could overcome staffing challenges more easily as well as to meet the ever changing care needs of the unit's patients.
- The unit had adequate facilities for relatives; for example, hot beverages, large waiting room areas, screens to aid privacy, patient information leaflets and overnight beds were all readily available.

Meeting people's individual needs

- Patients had their individual needs identified and taken in to consideration before care was delivered. This was reflected in the documents we viewed and in the feedback we received from relatives and staff.
- Decisions made about withdrawal of care were discussed with relatives and had a multidisciplinary approach. We saw evidence of this documented in the EPR.
- The senior nurse conducted routine 'care rounds' in order to interact with patients and their loved ones as well as to encourage communication about individual concerns with senior staff.
- Daily meetings were held to discuss the unit bed status, proposed admissions and discharges. This ensured that staff were continuously made aware of the necessary capacity and staff skill mix needed to deliver safe care.
- The unit had introduced a 'care passport' for patients. This document was a record of patients' individual needs, for example, communication issues, dietary preferences, sleep pattern, hobbies, likes and dislikes. This document assisted staff with being able to provide consistent, individualised care to their patients.
- Staff arranged themed evenings for long term patients. We were given numerous examples of how nursing staff had 'gone the extra mile' to ensure that awake patients had their psychological needs met. For example, a DVD night, pyjama parties and a night out themed party.
- There was a learning difficulty team available who provided specialist advice and support to patients and staff.
- The unit had two formal consultant ward rounds and an informal business round daily to review treatment plans and unit capacity. This was reflected in our observations and the medical records we viewed.
- The unit had implemented the use of dementia champions.
- We were told by staff how they met different religious needs of local patients with the assistance of the chaplaincy staff.
- We saw an information leaflet designed for patients and their relatives. It contained a range of useful information for example, a map of the unit layout, staff roles, facilities, visiting times, amenities, parking etc.
- Interpreting services were provided by the trust.
- When we asked staff in CCU what they would change about the service they provided, they told us they would like an activities coordinator for 'awake patients'. This would provide extra psychological stimulation and encourage sociability for this patient group.
- The unit had implanted a reduced care parking fee for relatives who made several trips to the unit daily. Information about this concession was included in the unit information guide.
- The service provided a critical care patient experience and follow-up service and had done so for the preceding 14 years. The benefits of the service have included a reduction in the length of stay for patients on both the critical care unit as well as their overall hospital length of stay. Through the use of ward follow-up visits for all patients who had received treatment for 5 or more days on the critical care unit staff have been able to promote the implementation of early rehabilitation, in line with national recommendations. Furthermore, patients were offered and routinely took up the opportunity to attend outpatient appointments at three and six months post-discharge to meet with a multi-disciplinary team including consultant intensivists, clinical psychologists, senior nurses and physiotherapists in order that the care they received whilst on critical care could be assessed and measured to assist in determining the extent of their recovery.

Critical care

Access and flow

- We inspected the trust in a period of unprecedented national demand. All 38 beds were in use during our inspection.
- Between May 2013 and July 2014, figures showed bed occupancy in the department was higher than the England average bed occupancy. Critical care bed occupancy for November, December 2014 and January 2015 was reported by NHS England to be 87%, 89.1% and 93.5% respectively for Salford Royal Hospital. There were no reported urgent cancellations during this time period which indicated that flow into the unit was managed appropriately.
- Despite the pressure on beds in the unit, data reviewed showed us that there were very low levels of elective or urgent surgical cancelations.
- The data we viewed and the conversations we had during the inspection did not highlight any concern with the current admission process. Medical staff had oversight of the process.
- The bed occupancy was noted to also exceed the levels recommended by the Royal College of Anaesthetics who recommend a maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers that carry associated risks. It is important to note that the trust had reported only 1 case of non-clinical transfer out of the unit in the preceding 12 months which indicated that flow into the unit was suitably managed.
- Between April 2014 and January 2015, the trust reported no mixed-sex accommodation breaches. This suggests that where patients were fit for discharge from an intensive care setting, but were experiencing delays, consideration had been given to ensuring that the patient was cared for in an appropriate clinical area.
- The unit performed worse that the national average for out of hours discharges. This affected approximately 6% of patients.
- Between January and March 2014, ICNARC data suggested that approximately 45% of patients could expect to experience a delay of between 4 hours but less than 24 hours from being discharged from the critical care setting. Approximately 12% of patients experienced a delay of between 1 and 2 days. The data we reviewed also suggested patients were unlikely to be discharged during the early stages of the day. We noted that 6% of the discharges from the CCU occurred out of hours. This is within the England average but significantly high for a unit predominantly caring for surgical patients.
- We found patients were admitted to the unit within the recommended four hour time frame. Additional support from recovery staff could be provided at busy times. We were aware that this support was utilised during the inspection to cope with the recent but national surge in demand for hospital care.
- The unit had on average 600 patients admitted every quarter and had an average length of stay reported as 4.5 days. The majority of patients have a low level of acuity (receiving level one or two care); a stay of 4.5 days could be considered a long stay for this type of patient. It is important to note that the average length of stay could be negatively affected by patients who required long term care such as spinal speciality patients. The trust reported a median length of stay of between 2.3 and 2.5 days.
- Data suggested the unit had a low re-admission rate within 48 hours which indicated that patients were being discharged from the CCU at a time when their clinical condition was appropriately stable.
- The unit had high levels of non-clinical transfers into the unit but had continuously maintained low levels of transfers out. On the occasions where a transfer was necessary, it was for a non-clinical reason.

Learning from complaints and concerns

- There were many methods used to collect data from patients and their relatives in the critical care unit, for example daily matron walkabouts, suggestion boxes and posters requesting suggestions as well as the service utilising feedback questionnaires.
- The follow-up team ensured completion of at least 5 patient feedback questionnaires per month.
- At 18 -month intervals a detailed postal questionnaire is sent to a cohort of the relatives of recently discharged patients and relatives of patients who passed away on the ICU. The questionnaire used was developed with advice from the critical care clinical psychologist. The response rate was 60%, generating approximately 100

responses. The questionnaires assessed a number of aspects of patient experience using a 5-point Likert scale, allowing the generation of detailed quantitative data, with spaces for free-text descriptive feedback.

- Themes from feedback with implications for practice were discussed at the monthly multidisciplinary clinical governance meeting.
- Examples of changes made to the service as a result of learning from complaints or compliments were: making various mobile phone chargers and hospital bleeps available for relatives, providing ear plugs and eye masks and utilising independent ventilator tubing holders to minimise the risk of injury.
- During the inspection we were made aware of a persistent concern relating to accessing the unit as the entrance door was locked at all times. Relatives complained of experiencing delays in staff members answering the door. Staff told us it was a concern during the day and more so out of hours. One of our inspectors experienced this problem this during the inspection. The trust however reported that the reception areas for the ICU were staffed daily between 8am and 8pm.

Are critical care services well-led?

Good

Staff felt they were well supported by their immediate teams and line managers and also at board level. Staff reported feeling proud to work for an organisation where they felt "they had a voice". They also told us that they were actively encouraged to become involved in change consultation and service improvement.

There was a clear vision and strategy for the service which staff felt empowered them to drive improvements from the 'front line'.

There was an effective governance structure that took account of incidents, quality improvement and took appropriate action when needed, and had a clear oversight of the risks to the service. Staff told us they felt very well led from a local and Trust perspective. Staff also told us they felt empowered to make suggestions to improve the service and were confident their opinions would be listened to.

We found a culture that reflected cohesive team working which appeared to be firmly embedded in everyday practice. There was also a genuine importance placed on a multi-disciplinary approach to care delivery. The recent staff survey demonstrated high levels of staff satisfaction at the Trust. The trust strived for continuous engagement and service improvement that was driven by staff, patients and members of the public.

Vision and strategy for this service

- There was a clear vision and goal for the service which aimed to become the safest NHS Trust in the UK.
- There were plans to incorporate the medical HDU into the critical care unit structure in due course. Nursing staff had already been integrated into one team which aided standardised care delivery and improved skill mix. This also meant that staffing could work flexibly and be deployed to cover unexpected staff vacancies without effecting care continuity.
- All the staff we spoke to were aware of the vision for the service and were proactively working towards ensuring the goals and visions were met.

Governance, risk management and quality measurement

- We found evidence of an effective governance structure in the Trust.
- We found evidence of a robust governance and risk systems.
- Taking account of key performance indicators, workforce issues and learning from incidents, complaints and patient experience was embedded into practice and reported accordingly to the board.
- We saw from the monthly quality performance report and risk register that there were clear lines of responsibility and communication.
- We found the service had effective processes in place for carrying out clinical audits and actions were taken when required to resolve concerns.
- Appropriate risk registers were maintained and reviewed and acted upon. Risks with a significant rating were escalated to the executive team for oversight and consideration.

Critical care

Leadership of service

- We found evidence of strong leadership in the department and staff reported feeling much supported by their immediate line mangers and staff at board level.
- The data we viewed and the conversations we had with staff demonstrated a high level of confidence in the leadership.
- Staff told us the executive team were very visible, including at weekends; we were given numerous examples of board members integrating with staff working on the front line. Examples included executives working with housekeepers, physiotherapists and shadowing nurses.
- We were told of the "pride" felt by senior managers who recognised that the critical care unit had produced, and continued to produce "quality leaders". Staff felt invested in and therefore progressed within the organisation.

Culture within the service

- We found a very consistent approach to team work in the department. Staff felt very proud of their ability to work well as a multidisciplinary team within the unit and across other departments.
- We noted a commendable 'buy in' by staff to the Trust ethos, values and vision. Staff told us their aim was to "Make sure patients were safe".
- The staff survey demonstrated high levels of satisfaction with all the indicators.
- Staff described the culture as one where "We all respect and listen to each other regardless of our roles", "Everyone is very happy working here" and "It's just a top hospital and people love their jobs".
- 86% of staff reported feeling satisfied with the level of care they provided at the trust compared with the England average of 78%.
- 76% of staff reported being able to contribute to improvements at work. This was better than the England average of 68%.

Public and staff engagement

- We found ample evidence that demonstrated the department actively encouraged public engagement.
- The trust had a dedicated for staff and public engagement on their website. The page had informationon consultations the Trust has undertaken with local community groups, key stakeholders and staff forums to ensure that we are working towards equal access to services and employment opportunities.
- Relatives told us they felt involved in the care delivered to their loved ones.
- Member of the public who attended the listening event told us they felt engaged with the trust.
- Staff told us they felt the trust engaged with them in a meaningful way and felt their opinion really mattered.
- They also told us about an open invitation to Trust board meetings.

Innovation, improvement and sustainability

- There was an incentive for staff who wished to get involved in helping the trust to make financial savings to the service. If an idea was adopted, the staff member received 10% of the overall savings as a reward for their innovation.
- Rotating junior staff to other areas within the unit to facilitate personal progression and encourage staff retention.
- Bleeps were provided to relatives in order that they could be contacted quickly by staff if they were away from the CCU.

Services for children and young people

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

Information about the service

There are no children's inpatient facilities at Salford Royal Hospital. Children's emergency services were provided via the PANDA Unit (Paediatric Assessment and Decision Area) which provides emergency and short stay (23 hour) care for children aged sixteen and under. This was a consultant led service where children could be assessed, investigated, observed and treated within 24 hours.

Salford Royal Foundation NHS Trust also provided paediatric ear, nose and throat (ENT) and paediatric dental day surgery. The main facilities for acute children's outpatients were based at the Pendleton Gateway Centre with additional clinics provided at two other sites.

In 2014, a total of 281 16-18 year olds were admitted to facilities within Salford Royal. The majority (214) were admitted into the emergency assessment unit(s). The Trust has a policy for the management of patients aged 0-18. Adolescent girls who were undergoing termination of pregnancy were treated at the hospital alongside adult woman.

We spoke with seven medical and 15 nursing staff, 5 children and their relative's, reviewed patient records and observed care being provided to children.

Summary of findings

Overall, we have rated this service to be good. The service was delivering care that was safe, effective, caring and responsive to the needs of children and their families. There was however some disparity between the overall strategy and vision with regards to the provision of care to children at Salford Royal Hospital and further work was necessary to strengthen this to ensure the service remained viable for the future. The disparity was in part, due to the existing clinical and operational structures of the hospital; we found that where services routinely treated children, such as the PANDA unit which was managed by the children's services directorate within the Salford Health Care division, governance arrangements, risk management and the measurement of performance was suitably robust. This was not necessarily the case for the relatively low number of children who attended the hospital annually to undergo routine day surgery. Whilst a senior clinician was accountable for overseeing the delivery of care to all children, this oversight was not sufficiently apparent for children requiring surgery.

The low number of children who underwent general anaesthetic at the hospital meant that anaesthetists and other staff in the operating theatres were at risk of not having the necessary regular and relevant paediatric practice sufficient to maintain their core competencies. The trust had acknowledged this as an area of concern in 2013 and had instigated a range of initiatives to reduce the potential risk to children; this included

commencement of scenario based training, as well as ensuring that two qualified anaesthetists were present for any child undergoing a general anaesthetic. The service had good incident reporting systems which staff were able to describe in detail. Staff were aware of their responsibilities to report incidents. Lessons were learnt where incidents had taken place. The department was visibly clean. There were systems in place to ensure that patients were protected from the risk of harm associated with hospital acquired infections. Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

There was evidence that staff used a range of local and national clinical guidelines to assist in delivering evidence based care. The service was recognised as being a leader in the provision of diabetes care to children and young people. Patient outcomes and clinical practice was audited to ensure that practice was consistent; where there had been deviations from clinical guidelines, or where auditing had identified variations in clinical practice, action plans were utilised to ensure a more standardised approach to care delivery. Within the Salford health care children's services directorate, we observed strong and effective multi-disciplinary team working amongst those involved in providing both acute and community based care to children and their families.

We observed children being looked after in a caring and compassionate manner. Parents and some children spoke about their care and how involved they were with planning their care and how information was shared with them so they could be fully informed on what would happen to them. Parental involvement was encouraged where they had children who were less than16 years of age, in line with national recommendations; this reduced the impact of hospitalisation on younger children.

The commissioning arrangements of children's services at Salford Royal Hospital meant that there were no in-patient facilities. Where children required hospital care lasting more than 24 hours, there were arrangements in place to ensure that children were transferred to an appropriate facility. There were arrangements in place for ensuring that where young people who required hospital care or admission, this was done in line with local hospital policy and only where the requirement to provide care had been appropriately risk assessed. Some improvements were required to ensure that there was age appropriate information available to children scheduled to undergo surgery.

Staff reported that leadership at a local, ward based level was good; managers were reported to be supportive of their staff and people spoke positively about working at Salford Royal Hospital. Staff visions and behaviours were aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care every time. A small minority of staff who worked within the day surgery unit reported that the improvements could be made to ensure that they received the necessary amount of sustained and consistent support from managers.

Services for children and young people

Are services for children and young people safe?

Good

The low number of children who underwent general anaesthetic at the hospital meant that anaesthetists and other staff in the operating theatres were at risk of not having the necessary regular and relevant paediatric practice sufficient to maintain their core competencies. The trust had acknowledged this as an area of concern in 2013 and had instigated a range of initiatives to reduce the potential risk to children; this included commencement of scenario based training, as well as ensuring that two qualified anaesthetists were present for any child undergoing a general anaesthetic.

The service had good incident reporting systems that staff described in detail. Staff were aware of their responsibilities to report incidents. Lessons were learnt where incidents had taken place.

The department was visibly clean. There were systems in place to ensure that patients were protected from the risk of harm associated with hospital acquired infections. Staff undertook regular training to ensure they could recognise and respond to the needs of vulnerable patients.

Incidents

- A total of 77 incidents were reported via the trust's incident reporting system between July and October 2014 which were attributed to the PANDA unit. None of those incidents were categorised as "serious incidents". We reviewed each of the 77 incidents that had been reported; there was evidence that senior members of the team had reviewed each incident. Each incident had detailed information regarding any immediate action taken as well as any action taken as a result of any subsequent investigation.
- We spoke with a range of medical and nursing staff. They were able to describe the incident reporting system, Datix©, and they were able to explain their roles and responsibilities with regards to the reporting of incidents. Furthermore, staff were able to explain, and provided examples of how lessons learnt had been generated from incidents and accidents.
- We were given examples of learning from an incident which resulted in improving observations on children when being triaged. Further examples included where an incident occurred in the paediatric assessment and decision area (Panda Unit) where it was reported that a fracture had been missed. It was investigated and revealed that the clinician did not recognise the fracture on the x-ray. Further training was given.
- Staff attended morbidity and mortality meetings and also attended Sudden Unexpected Child Death meetings which were also attended by a range of external stakeholders.

Nursing Assessment and Accreditation System (NAAS) & Safe, Clean and Personal Care Every Time (SCAPE)

- A nursing assessment and accreditation score process formed part of the performance targets for all wards. These were said by matrons to be linked to the principles of 'Safe, Clean and Personal care to every person, all of the time', (SCAPE). Wards were assessed and the outcome resulted in a colour score, with opportunities for improvement through re-assessments at four monthly intervals. Ratings were given based on the assessment of specific criteria. As of January 2015, the PANDA unit had attained green status with regards to the NAAS & SCAPE initiative. SCAPE accreditation (blue) was deemed to be the optimum achievable score.

Cleanliness, infection control and hygiene

- Staff working in the unit had a good understanding of their roles and responsibilities in relation to cleaning and infection control practices.
- The PANDA unit, surgical day care unit and outpatients clinics were visibly clean and well maintained.
- Cleaning schedules were in place and there were clearly defined roles for cleaning and decontaminating equipment. Cleaning schedules were documented and audited for compliance. The surgical day care unit had an annual schedule for deep cleaning which was monitored.
- We observed staff carrying out regular hand hygiene practices and wearing personal protective equipment such as gloves and. The department attained 100% compliance with hand hygiene practices in December 2014.

- Arrangements for the handling, storage and disposal of clinical waste were in place in clinical areas.
- 88% of nursing staff and 67% of medical staff working on PANDA unit had completed aseptic non-touch technique training; the uptake of training was below the trust target of 95%.
- 100% of nursing staff had completed e-learning modules relating to both MRSA and C.diff.
- 94% of nursing staff and 83% of medical staff had completed infection control training. These uptake rates were below the trust target of 95%.
- 100% of nursing staff had completed hand hygiene induction training.

Environment and equipment

- Equipment was found to be in date and staff told us there was sufficient equipment available at all times.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- Age appropriate resuscitation equipment was available and there was evidence that this has been regularly checked.
- 93% of nursing staff working on the PANDA unit had completed medical equipment competency training. This was slightly below the trust target of 95%.

Medicines

- Medicines and controlled drugs were secured safely and we observed medicines being administered to patients following patient group directives. (PGD's).
- Medicine and controlled drug cupboards were locked and there was evidence that fridge temperatures were checked and documented daily.
- We checked medication records which demonstrated good record keeping standards.
- A pharmacist was noted to support the PANDA unit; we observed a pharmacist carrying out routine checks on medication stock to ensure that there was sufficient supply and that medicines had not exceeded their expiry date.

Records

- We noted that care plans were comprehensive and person-centred. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.
- 100% of administrative, clerical and medical staff had completed information governance training. 94% of nursing staff working on PANDA unit had completed this training versus a trust target of 95%.
- Patient discharge summaries were issued within 24 hours in 85% of cases between April and November 2014. This was worse than the trusts expected performance rate of 95%.
- Clinical letters for patients seen by the paediatric dermatology service were issued within 5 days in 89.6% of cases between April and November 2014. This was worse than the trusts expected performance rate of 95%.

Safeguarding

- Managers and staff members demonstrated a clear awareness of the referral process they must follow should a safeguarding concern arise within the PANDA unit.
- Staff were trained in safeguarding children and there was evidence of links with the designated leads for safeguarding. 100% of nursing and medical staff had completed safeguarding vulnerable adults training. 91%, 88% and 100% of nursing staff had completed safeguarding children 'Group 1', 'Group 2' and 'Group 3' training respectively.
- The trust had a safeguarding policy, a designated consultant safeguard lead and a designated safeguarding nurse.
- There was an electronic flagging system that identified children admitted to the PANDA unit who were identified as being 'at risk' or being supported by a social worker. Staff on the unit contacted the social worker to notify them of the child's attendance.

Assessing and responding to patient risk

- The trust used a paediatric early warning score system (PEWS) to ensure the safety and well-being of children. This system enabled staff to monitor a number of indicators that identified if a child's clinical condition

was deteriorating and when a higher level of care was required. Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately.

- There was a process in place for referring children who presented to the department and who were acutely unwell to more appropriate clinical settings such as the local children's hospital located in Manchester.
- There were arrangements in place to ensure that children, who required intensive care support, were retrieved by a specialist children's ambulance retrieval service.
- We observed the paediatric recovery bay within the surgical day care unit: resuscitation equipment for children was up-to-date and fit for purpose. The paediatric operating theatre was located close to the recovery area and recovery staff had been trained in paediatric life support.
- 67% of medical staff and 83% of nursing staff working on PANDA unit had completed paediatric basic life support training. These rates of training were lower (worse than) than the trust target of 95%.

Nursing staffing

- The trust reported a nursing vacancy rate of 15% within the Panda unit. A total of 16.2 whole time equivalent staff were employed to support the service. The nursing staff turnover rate was generally low with; 5% turnover reported between 2012/2013, 10% for 2013/2014 and 6% between July and September 2014.
- The average sickness rate amongst nursing staff on PANDA unit was reported as 6.4% over a 10 month period between December 2013 and September 2014. Sickness rates were seen to improve over time with a reported rate of 0.5% in September 2014.
- Recruitment of suitably trained children's nurses was reported as a risk on the children's service risk register. This risk had been recorded as a 'moderate' risk to the clinical effectiveness of the department. Contingency arrangements had been implemented including the rotation of nursing staff between the emergency department and the PANDA unit.
- Limited availability of children's nurses available from NHS Professionals was reported as gap in the assurance measures which had been introduced to mitigate the risk associated with an overall lack of children's nurses in the department.
- The PANDA unit was supported by two trained children's nurses and one support worker on the morning shift; this increased to four trained nurses and two support workers later in the day when attendances to the unit increased.
- Seven incidents were reported between August and October 2014 which related to either a shortage of children's nurses or a shortage of experienced nursing staff to support the PANDA unit.
- Staffing at Pendleton Gateway, where children were seen as outpatients, met the demands of the service with staffing levels being titrated to ensure there was sufficient cover to meet the needs of patients in each clinic.
- Children who underwent day-case surgery were cared for by qualified children's nurses.

Medical staffing

- The PANDA unit employed a total of 16 whole time equivalent medical staff. The unit was supported by six consultant paediatricians and one nurse consultant. The level of consultant staffing was reported to be better than the national average (66% versus 34% nationally).
- The turnover rate for substantive medical staff was reported as remaining 0% since April 2013. Furthermore, the sickness rate amongst the medical cohort was also reported as 0% since August 2013.
- The usage of locum medical staff was seen to be low, and in the main, infrequent. Peaks in usage were noted in December 2013 (16.4%) and in April 2014 (15%).
- Some medical staff, specifically from the anaesthetic department raised concerns with us that they felt 'uneasy' when having to look after acutely unwell children for prolonged periods of time in the PANDA unit whilst waiting for the child's transfer to another hospital. Some anaesthetists felt this to be a risk as looking after a critically ill child was a rare occurrence and as such,

medical staff lacked the skills to carry this out safely. We reviewed the incidents associated with PANDA unit and did not identify any incidents to help corroborate the concerns raised.

- Some anaesthetic staff raised concerns that due to the relatively small number of paediatric surgical cases that were undertaken annually, there were insufficient numbers to ensure anaesthetists would be proficient in anaesthetising young children. During the period January 2014 to December 2014, 432 operations took place with five anaesthetists providing. The majority cases were reported to have been carried out by two named anaesthetists resulting in the three remaining anaesthetists undertaking significantly fewer cases. The concern was around whether managing such low numbers of anaesthetics for children allowed anaesthetists to have regular and relevant paediatric practice sufficient to maintain their core competencies.
- We raised these concerns with the trusts' executive team who responded promptly with a range of assurances and actions that were to be undertaken in order to ensure that the risk to children was mitigated as far as possible. The trust explained that the concerns raised with us had originally been raised by the anaesthetic department in November 2013 where the low levels of paediatric activity had been discussed as part of a surgical service review. We were advised that a meeting had been held between the trust and the paediatric anaesthetics team on 22 January 2014 where it was agreed that, due to the activity within the PANDA unit, paediatric anaesthesia services would continue to be provided. Risks had been mitigated by ensuring that two anaesthetists were always present for each surgical case and that all anaesthetists would be provided with "Managing Emergencies in Paediatric Anaesthesia" training. Additionally, a paper was submitted to the Executive Assurance and Risk Committee in March 2014 where it was decided that the Clinical Effectiveness Committee would decide from one of three proposed actions, namely: 1) Stop paediatric anaesthesia services 2) increase the number of paediatric cases or 3) provide simulation training as was agreed during the meeting in January 2014. Option three was the preferred course of action, from which the trust have advised that approximately 90% of relevant anaesthetists have undertaken scenario training. An additional meeting was held with the Medical and Nursing Director in November 2014 during which it was considered that progress had been made but that scope to increase paediatric cases further was noted. Following our feedback, further engagement has been undertaken between the lead for paediatric anaesthesia and the medical director and a remedial action plan has been implemented. It is important to note that we have not yet considered the overall effectiveness of the proposed action plan.

Operating Department Practitioners

- Operating Department Practitioners also raised concerns in relation to their competencies in responding to a paediatric resuscitation call or to having to assist an anaesthetist when a child was being treated in the high dependency bay on the PANDA Unit. Again this was due to the low numbers of children coming through the operating theatres.

Major incident awareness and training

- The children's service had its own business continuity plan. This document described how the service would respond to a major incident and how the service would continue to function in such an incident.
- However, whilst there were emergency action cards for Paediatric advanced nurse practitioners, paediatric senior nurses and the paediatric co-ordinator, the PANDA unit was not included in the trusts overall major incident plan and had not been part of the overall major incident testing. This was contrary to the guidance issued by the Royal College of Paediatrics and Child Health (RCPCH) in their document 'Standards for Children and Young People in Emergency Care Settings' (2012).
- Staff on the PANDA unit had carried out an evacuation procedure for fire testing.

Are services for children and young people effective?

Good

The trust utilised a range of policies and guidelines which were based on national guidance. Auditing of compliance with national guidelines took place; where there was identified poor compliance action plans were developed to address the shortfalls.

Services for children and young people

Whilst there was some evidence of multi-disciplinary working, the trust did not have a formalised paediatric surgery committee which was contrary to national recommendations.

There were systems in place to ensure that the clinical, psychosocial and general health needs of children could be met; this was delivered through a comprehensive assessment process which was family centred.

The trust performed well on the national audits for epilepsy and diabetes. Whilst readmission rates were high, the trust maintained a 96% discharge rate within 24 hours from the PANDA unit.

Evidence-based care and treatment

- The service took part in a number of national audits such as those for Asthma, Epilepsy and Diabetes.
- Regular audits were undertaken for record keeping and infection control. We saw that changes were made from the outcomes of these audits to enhance patient safety.
- The service reviewed their performance against a range of National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SICE) guidance. This included compliance against management of children of acute otitis media and tonsillitis. An audit of performance and compliance against local policies with regards to acute otitis media was carried out in in December 2013; 6 of 7 eligible patients received antibiotics as per local guidelines however only 2 of those patients received antibiotics for the recommend period of time. 2 patients who did not meet the criteria for requiring antibiotics, received antibiotics. Of the 12 audited patients, only 5 patients were treated correctly.
- With regards to the management of children presenting with symptoms of tonsillitis, 18 patients received antibiotics according to guidelines. Of the 18 patients, only 8 children received the recommended antibiotic for the correct duration of time. Of the 20 patients that did not meet the criteria for antibiotics, 18 received antibiotics. This meant that 10 out of 38 patients who were audited were treated in line with local and national guidance.
- The conclusion from the audit indicated that the trust were not robustly following NICE/SICE guidance with over-prescribing of antibiotics for patients with tonsillitis and further work was required to review existing practices.
- Compliance with documentation of child protection medicals undertaken on the PANDA unit was mixed. 84% of letters were dictated within 24 hours, of which 68% were dispatched within 3 days. Only 29% of school nurses and/or health visitors received a copy of the child protection medical letters. Height and weight measurements were not recorded in 66% of cases and 62% of cases were sent home without a discharge summary. 42% of under 5's had a full developmental assessment documented. Follow-up arrangements were recorded in 84% of cases, with recommendations noted in 91% of cases. 100% of cases had a clinical opinion documented. An action plan was developed to address the areas which required improvement; a re-audit was scheduled for February 2015.

Pain relief

- Children received the appropriate level of pain relief; there were pain assessment tools used for children of different ages. For information these were posted around the PANDA Unit for all staff and parents to view.
- The use of paediatric pain assessment tools was audited regularly.
- Topically applied local anaesthetic was applied routinely prior to cannulation.
- An audit of patients who presented with acute otitis media was conducted in December 2013. 9 of the 12 patients had a documented pain score. 3 of the 9 patients received analgesia. The department considered this area to be a fail with regards to this component of care and further work was required to improve performance.

Nutrition and hydration

- The trust policy was that children were fasted pre-operatively to reduce the risk of aspiration of the stomach contents. The times given in the policy were in

accordance with the recommendations of the Royal College of Anaesthetists. Children could have water and clear fluids up to 2 hours prior to surgery and food up to 6 hours prior to their operation.

Patient outcomes

- **The trust was not a CQC outlier in respect of any aspect of care of children and young people.**
- The trust performed well in the National Paediatric Diabetes Audit published in 2013. The share of children with an HbA1c level of less that 7.5 was 18.8% compared to the England average of 17.4%.
- The children's service has been nationally recognised for their diabetes and epilepsy care through their audit programme.
- The re-admission rates for children within two days of discharge for non-elective admissions were generally higher than the England average. This was true of both very young children under one year of age and those aged up to 18 years.
- During the period June 2013-May 2014 the paediatric re-admission rate for babies under one year of age was over twice the national average during the same period (7.5% vs 3.3% nationally). For children aged between 1 and 17 years the figures were similar with the trust rate of re-admission being over twice the national average (6.7% vs 2.8% nationally).
- Similar figures were seen for non-elective ENT re-admissions with a re-admission rate of 5.9% compared to a national figure of 1.6% for children aged 1 to 17 years. These figures suggest that some children may have been discharged prematurely.
- Whilst multiple admission rates for children with diabetes and epilepsy were below (better than) the national average, the rate for children who had multiple admissions for asthma was worse than the England average (26.6% for the trust compared to 16.8% nationally).
- The trust was identified as a positive outlier one area in the Epilepsy12 Audit for 2014 (Water safety). The trust was not identified as a negative outlier in any area.
- 96% of patients receiving treatment under the epilepsy care pathway rated that they were overall satisfied with the service they received. This was better than the national average of 88%.

Competent staff

- Staff appraisal across the three areas where children were cared for was 92%.
- All staff undertook basic life support (BLS) training and paediatric life support (PLS) training annually. However, not all staff on the PANDA unit had Advanced Paediatric Life Support (APLS) training. Nursing staff told us that the APLS course required additional funding and staff who wished to be trained in APLS had to pay for half of the course costs themselves, despite this qualification being a requirement in their job description. The Royal College of Paediatric and Child Health recommend that all registered nurses who are employed at band 6 and above in urgent care settings should have current APLS training (Standards for Children and Young People in Emergency Care Settings, 2012). 84% of consultants and 88% of advanced nurse practitioners had completed training in advanced paediatric life support with 4 consultants and 1 ANP being listed instructors. 15% of nursing staff had undertaken the APLS course with 1 listed as an instructor.
- There were six Advanced Nurse Practitioners on the PANDA unit who functioned at a level alongside junior doctors but who undertook nursing activities, if needed. They were additional to the nursing staff on duty through the day. Clinical oversight and competence of the advanced nurse practitioners was provided from a named paediatric consultant.
- The PANDA unit worked with the accident and emergency department in providing experience for seconded nursing staff from the accident and emergency department to the PANDA Unit to enhance their skills in caring for sick children.
- 88% of nursing staff working on PANDA unit had undertaken 'Safe Blood' competency training versus a trust target of 95%.

Multidisciplinary working

- We observed good working relationships between all grades of staff and all professional disciplines working on the PANDA unit.

Services for children and young people

- Staff in the accident and emergency department reported that they worked closely with the PANDA unit staff. It was identified on the children's risk register that following the move of the adult ED to a new build, ED consultants were no longer undertaking dedicated sessions within the PANDA unit. The risk raised concerns including 1) PANDA unit being covered approximately 60% of the time by consultants who had "very little or no emergency trauma training" 2) "Poor oversight of trauma management, especially minor injuries" (a hypothesis was listed against this risk suggesting that "more children were x-rayed than was perhaps necessary"). 3) "Poor training in the area of trauma for the General Practice Vocational Trainees", 4) "Poor training for ED middle grade doctors" 5) "Exposure of trust and paediatric consultants to litigation as they are working in an area where they do not have Certificates of Completed Training (CCT) accreditation" 6) "Reduced flow in the department as the PANDA team have to phone/ go to adult ED for any advice" 7) "The pressures on the adult ED prevent a consultant attending the PANDA unit". A range of established controls had been implemented to mitigate risks including ensuring that ED consultants attended the PANDA unit to provide advice when requested by a paediatric consultant. Additionally, the risk register indicated that a "PANDA Development Group" had been established in October 2014. The group consisted of a range of healthcare professionals from both the ED and PANDA unit and included representation from clinicians, nurses, advanced nurse practitioners and senior management. The remit of the group was to develop an escalation policy, operational policy, transfer policy and to develop and strengthen relationships amongst health care professionals between PANDA and the ED.
- There was no formal, established paediatric surgery committee; this was contrary to recommendations from the Royal College of Surgeons and this detracted from effective multi-disciplinary working.

Seven-day services

- The PANDA unit provided a seven day service with consultant presence; it is important to note that the service was designed to provide care to individual children for a duration of no longer than 23 hours and 59 minutes. Where children required further in-patient care and treatment, arrangements were in place to transfer children to local inpatient facilities.
- Children were only admitted for day case surgery on morning lists. This reduced the likelihood of delayed discharge. If a child became unwell peri-operatively there were systems in place to ensure that the child was stabilised and then transferred to the PANDA unit for further assessment; alternatively, children could be transferred to hospitals where paediatric inpatient facilities were available.

Consent

- Staff told us how consent was obtained from parents and where appropriate from the child or young person concerned on the PANDA unit. Consent was obtained in line with trust policy and the principles of Gillick competency assessment.
- The World Health Organisation surgical safety checklist, which included checking for patient consent was used on the Surgical Day Care Unit, but was not audited to monitor how well staff were complying with the policy on seeking consent from children and young people.
- Staff on the Surgical Day Care Unit told us that they were waiting for this procedure to be added to their electronic management system, so that if the WHO checklist was not completed then the next stage of the surgical process could not be progressed. We were told by a group of Band 7 nursing staff from across the hospital that there was a waiting list of between 18 and 24 months for documents to be added to the system: There was no mitigation of this risk in the interim.

Are services for children and young people caring?

Good

We observed children being looked after in a caring and compassionate manner. Parents and some children spoke about their care and how involved they were with planning their care and how information was shared with them so they could be fully informed on what would happen to them.

Services for children and young people

Parental involvement was encouraged where they had children who were less than16 years of age, in line with national recommendations and this reduced the impact of hospitalisation on younger children.

Compassionate care

- We observed children and families being looked after in a caring and compassionate manner.

Understanding and involvement of patients and those close to them

- Feedback from children and parents was discussed at team meetings and patient stories were shared regularly at directorate meetings to improve staff understanding of what being a young patient or parent with a young patient felt like.
- Feedback from most parents was positive although some parents felt they didn't always know what was happening whilst waiting to be seen after triage. Once a child had been triaged they would be sent into the waiting area for the PANDA unit, this area was not staffed although there was CCTV to ensure people were safe.
- We observed staff talking with parents and children, explaining their treatment and giving information about the next steps
- Parents were encouraged to remain with their children whenever possible. Parents accompanied their child to the Surgical Day Care Unit for surgery and had a separate waiting room whilst their child was having surgery. As soon as the operation was completed the parent returned to their child immediately.

Emotional support

- We saw staff interacting with parents and children in a polite and friendly manner.
- If there was an unexpected death of a child staff knew the protocol to be used. There was a paediatric bereavement officer in the trust. Chaplaincy services were also available to provide support; there were provisions for ensuring staff could call on the chaplaincy service out of hours.
- Parents with children on the PANDA unit or having day surgery could remain at all times and were the mainstay of emotional support for children.
- Parents were encouraged to go to the operating theatre with their child to minimise their anxiety and also to go to the recovery area as soon as they had regained consciousness to bring them back to the ward accompanied by a registered children's nurse.

Are services for children and young people responsive?

Good

The PANDA unit met the needs of young patients (0-16 years) and their parents or carers well. There was ready access to the unit via the accident and emergency unit of via a GP referral and a seven day service was provided. Close working arrangements with community based services ensured that children could expect to be discharged within 24 hours.

There were formal arrangements in place for children to be transferred to other local hospitals if prolonged in-patient care was required.

Whilst the trust website provided access to downloadable leaflets and details about the services they provided, there were no leaflets suitable for young children. However, children were invited to attend a pre-assessment clinic in order that the child could meet with the play specialists and nursing team, and an opportunity was provided for children and their parents/carers to ask any questions.

Access and flow

- The trust had reviewed attendances of children to the accident and emergency department over a period of time and identified that the peak time for children attending the department was between 1pm and 9pm; a qualified children's nurse was therefore available during this time to carry out an initial triage of children who presented to the department. For the remainder of the time a general accident and emergency department trained nurse triaged children. Children were then sent through to the waiting area in the PANDA unit. Waiting times were updated hourly on the white board for parents to view.
- Joint working with paediatric, emergency medicine consultants and community nursing staff ensured that over 96% of children attending the PANDA Unit were discharged home direct from the unit.

Services for children and young people

- There were arrangements in place for the transfer of critically ill children to specialist centres by the North West Transport Service (NWTS). We were told by staff that these arrangements worked well and policies for the transfer of patients could be accessed electronically.
- Nursing and medical staff told us that there were concerns when there were insufficient beds in neighbouring hospitals; this resulted in some children having to stay for longer periods of time on the PANDA unit. This was considered by the paediatric team at the trust to be one of the most significant risks to the clinical effectiveness of the PANDA unit and was logged as a moderate risk on the risk register. Breaches of patients staying longer than 24 hours on the PANDA unit were audited and reported as an incident to determine whether any service improvements were required.
- A review of evidence provided by the trust indicated that the flow into and out of the PANDA unit was well managed. A total of 304 children required transferring from the PANDA unit to one of 9 local paediatric inpatient facilities between April and October 2014. 11 incidents were reported by staff between July and October whereby there were no available beds at the local children's hospital. One incident was reported whereby a child remained as a patient on PANDA unit for more than 24 hours due to a lack of capacity at the local hospital.
- The surgical day care unit had a dedicated waiting room, post-operative area and recovery room for children.
- Referral from a GP to treatment time for general paediatric patients was 11-12 weeks. Children could be seen urgently as additional appointments times were left vacant at the beginning of outpatient's clinics. There were ad-hoc rapid access clinics for follow up for children who had previously attended the PANDA unit.
- Outpatients' clinic appointments were allocated six weeks in advance. Patients were sent reminder texts prior to their appointment in order to reduce the frequency of non-attendance.

Meeting people's individual needs

- There were a number of posters and information leaflets around the PANDA unit and outpatients department. These were available in a total of nine different languages. However, leaflets used in the surgical day care unit were not specifically written for children.
- There was a lack of information about children's surgery at Salford Royal Hospital. The trust website simply said, "A paediatric theatre list also takes place at SRFT". There were no downloadable leaflets appropriate to children or their parents/carers, even when a procedure was frequently carried out on children (such as grommet insertion). Children were however invited to attend a pre-assessment clinic prior to their operation; staff were able to offer parents/carers and children an opportunity to ask questions regarding their proposed procedure.
- The PANDA unit was designed to provide care and treatment to children aged up to 16 years. Young people aged 16-18 years were cared for predominantly on the emergency assessment unit as per the local hospital policy.
- Adolescents who presented with self-harm injuries were treated in the adult accident and emergency department. Children who presented with a mental health problem could be cared for in a suitable room in the main accident and emergency department, if necessary, whilst awaiting assessment by the Child and Adolescent Mental Health Service (CAMHS). CAMHS could be accessed 24 hours a day.
- The PANDA Unit had two play specialists who were responsible for providing activities for children. Age appropriate toys were available. Adolescents were able to access to Wi-Fi network which had been introduced as a result of a survey undertaken by a member of staff.

Learning from complaints and concerns

- Learning from complaints was shared via team meetings. Staff told us they received feedback after a complaint was made either by email or by daily staff huddles.
- There were very few formal complaints received which related to the care of children.

Are services for children and young people well-led?

Services for children and young people

Requires improvement

There were systems in place to ensure good governance and monitoring of standards for children who required acute medical care. Improvements were however required to ensure that the same level of monitoring and governance of standards existed for the relatively small number of children who required surgery.

It was apparent that staff were proud to work for Salford Royal NHS Foundation Trust. Staff were aligned to, and supported the trust wide vision of providing safe, clean and personal care. Leadership of individual aspects of children's services was good with staff speaking positively about their immediate team leaders. There were however some exceptions to this with some operating theatre staff feeling they lacked leadership oversight and had little voice in how their role developed.

Vision and strategy for this service

- Staff spoke positively about providing high quality care that was aligned to the trust-wide vision of ensuring that patients received safe, clean and personal care.
- Staff members were aligned to the trust wide quality improvement strategy and were able to describe the five key aims of said strategy.
- We identified that there was no all-encompassing vision or strategy which was attributed to the overall provision of children's services at Salford Royal Hospital.

Governance, risk management and quality measurement

- The Salford Health children's services directorate had 33 risks on its risk register with action plans and controls in place to reduce risks.
- The arrangements for governance, risk management and quality measurement associated with the care of children was varied across the trust. We found that the division of Salford Healthcare had appropriate arrangements in place which enabled them to measure the quality of the services they provided, as well as having appropriate governance systems in place.
- The division of Salford Healthcare had, within its governance arrangements a children's services directorate which facilitated children's operational meetings which took place fortnightly with one meeting concentrating on clinical matters, the other reviewed operational issues.
- The meetings included telling a 'Patient story' which helped remind staff of the reasons behind why they worked within the service and to consider and reflect on situations when the delivery of care had not gone according to plan; these sessions allowed staff to learn from the incident and to consider and implement any actions that may have needed to be taken. Furthermore, these meetings considered reviews of policies, medical pathways, reviews of existing and new risks, safeguarding concerns and financial and human resource performance.
- It was not clear how the governance arrangements for children who attended the day surgery unit worked. A review of minutes for the Salford Healthcare Children's services directorate operational meetings, clinical governance meetings and clinical effectiveness meetings did not take into consideration incidents, outcomes, complaints or risks associated with children who were admitted for day surgery.
- When we arrived for the inspection visit we were told by a member of the executive team that the PANDA unit was the only service for children at the hospital. They were not aware that children's surgery was being undertaken at the hospital; we had to visit the surgical day unit to ascertain that they were operating on children.
- We were told by senior staff that Salford Royal was "An adult hospital" and this perception had led to the paediatric services being bolted on to adult services rather than considered as a speciality that needed appropriate leadership and governance arrangements.

Leadership of service

- Staff working with children on a daily basis (PANDA unit) reported that day-to-day clinical leadership was good. Staff told us that they received support from their immediate line managers.
- Surgical services for children were neither led nor co-ordinated in accordance with national guidance. At the time of the inspection, the trust did not have a formal paediatric surgical committee.

Services for children and young people

- The hospital had a named senior clinician who assumed the responsibility for being accountable for and having oversight of children being cared for at Salford Royal Hospital. However, whilst oversight of the provision of care for children receiving care via community paediatric and ambulatory care services was sufficiently robust, there was a requirement for oversight of children undergoing surgical procedures to be significantly strengthened.

Culture within the service

- Most staff that we spoke with told us Salford Royal NHS Foundation Trust was 'a great place to work' 'amazing' and 'it feels safe'.
- However, some staff in the Surgical Day Care Unit felt morale was low due to a high turnover of managers and the implementation of a new scheduling regime. ODP's had no principle lead which resulted in some ODP staff feeling there was no leadership for their staff group.

Public and staff engagement

- There was no friends and family test for children's services although we were told that the PANDA unit had a project in progress to survey children and parents about their care on the unit.
- There was no feedback mechanism specific to children undergoing day surgery at the hospital.

Innovation, improvement and sustainability

- The diabetes outpatient service demonstrated good practice where children in transition from young people to adulthood were seen in a clinic attended by an adult physician and adult specialist nurses, giving dietetic and psychological support. This ensured a continuous and consistent pathway of care through to adulthood.

End of life care

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

Information about the service

Salford Royal NHS Foundation Trust (SRFT) provides integrated end of life care across the hospital and the community setting. End of life care was not seen as the sole responsibility of the Specialist Palliative Care Teams(SPC's) but was considered as an integrated service, for which every member of staff was responsible for.

The Specialist Hospital Palliative Care (HSPC) service is delivered via a multi disciplinary approach and consists of a hospital and a community palliative care team who work in partnership with a local voluntary sector hospice provider, St Ann's, to provide support to patients with complex symptoms at the end of life.

A hospital practice development lead and an end of life clinical facilitator were available across the hospital to support training and education of the hospital SPC team and nursing and medical staff.

The specialist palliative care teams were lead by palliative care consultants and a nurse consultant. SHPC clinical nurse specialists(CNS) worked across all areas of the hospital and with their community palliative care and bereavement colleagues. In addition, the bereavement team provide bereavement support during end of life care and after the death of a relative; a chaplaincy team provided multi-faith support.

The hospital based palliative care team are available seven days a week, providing cover between the hours of 8.30am and 4.30pm. Outside these hours, the HSPC service is provided by way of telephone support provided via St Ann's hospice.

During the inspection we visited a variety of wards and departments across the trust including wards L8, L4, H2, B8, the haematology, renal, critical care, cardiac care and the acute stroke units, bereavement centre, mortuary, the Macmillan information centre and the chaplaincy to assess how end of life care was delivered.

We spoke with palliative care medical and nursing consultants,a palliative care CNS, the bereavement team leader and trainer, ward managers and nursing staff, porters, mortuary staff, the trust's organ donation lead, the hospital chaplain, patients and relatives.

We reviewed documents relating to the provision of end of life care provided by the trust and the medical records of nine patients receiving end of life care. We observed care being provided by medical and nursing staff on the wards. We spoke with one patient who was receiving end of life care and with the family members of three patients who were also receiving end of life care.

We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

End of life care

Summary of findings

The hospital Specialist Palliative Care(HSPC) team provided face to face support seven days a week, with the hospice providing out-of-hours cover. There was strong clinical Leadership of the HSPC team resulting in a well developed, strong, motivated team. A strong bereavement team was available to support carers and families following the death of their relative. The teams worked well together to ensure that end of life policies were based on individual need and that all people were fully involved in every part of the end of life pathway.

Relatives of patients receiving end of life care were provided with free car parking and open visiting hours. Families were offered 'keepsakes' including fingerprints, photographs and locks of hair. Families were given the choice of how their relative was moved to the mortuary. Relatives received these family members belongings in canvas bag with a 'swan logo' which highlighted to staff that people caring the bag may need extra support. There was excellent spiritual /religious awareness across the hospital and facilities were in place to support the different cultures and religions of the people of Salford.

End of life care was embedded in all the clinical areas and staff we spoke to were passionate about end of life care and the need to ensure that the wishes and preferences of their patients and families were met as they entered the last stage of their life. Palliative care link nurses were introduced onto the wards to champion good end of life care.

There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their Preferred Place of care(PPC) or Preferred Place of Death(PPD).Patients were discharged within a 6 hour window.

Patients were cared for with dignity and respect and received compassionate care.

Medicines were provided in line with guidelines for end of life care.

Are end of life care services safe?

Good

End of life care at Salford Royal NHS Foundation Trust was safe. We found there was a culture where staff were encouraged to report adverse incidents and there was evidence of learning from incidents. However, we noted that mortuary staff were not utilising the incident reporting system to log 'code red' capacity issues.

There were sufficient numbers of specialist medical and nursing staff to meet the needs of patients at the end of their lives. Systems were in place for the safe management of medicines. The equipment needed for dying patients was easily available and well maintained.

Incidents

- Each member of staff that we spoke with told us they were encouraged to report incidents, near misses and any incidents which had caused actual harm via the electronic incident reporting system, Datix ©. However, it was noted that mortuary staff did not routinely log 'code red' capacity issues using the Datix incident reporting system and that local escalation protocol took place in line with the mortuary escalation policy.
- Several staff described incidents they had reported and had received feedback.
- The trust provided data about incidents reported in the six months before our inspection with summaries of action taken to mitigate the risk of reoccurrence. Incidents were recorded by speciality or location; there was no specific code for incidents related to end of life. Staff told us incidents related to end of life care were reported to the lead nurse 'if appropriate'.

  When we looked at the list of incidents across the trust we found several incidents in various locations and specialities which related to patients at the end of their lives (EOL). For example, four of the ten incidents reported by mortuary staff related to omissions in the care of patients after they had died on the wards.

End of life care

Cleanliness, infection control and hygiene

- The wards, mortuary and viewing areas we visited were visibly clean, bright and well maintained. In all clinical areas the surfaces and floors were covered in easy to clean materials allowing hygiene to be maintained throughout the working day.
- Ward and departmental staff wore clean uniforms and observed the trust's' bare below the elbow' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary we observed adequate supplies of PPE for use by visiting undertakers, porters and police.
- We observed staff challenging visitors to wash their hands upon entering clinical areas or prior to and after having made physical contact with a patient.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or whilst caring for people after death in the trust's 'Care after death' policy.

Environment and equipment

- The trust used McKinley T34 syringe drivers to deliver consistent infusions of medication to support end of life patients with complex symptoms. We noted that syringe drivers were available across the trust.
- A syringe driver was stored in the 'emergency cupboard' on the EAU if required for out of hours use. Syringe drivers were routinely cleaned by ward staff before being returned to the hospital pharmacy. The pharmacy team was responsible for the maintenance of the equipment.
- Pressure relieving equipment was available for patients requiring them. Staff confirmed that alternating pressure mattresses were supplied within four hours by the contractor used by the trust. We saw these mattresses in use for patients receiving end of life care during the inspection.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in all areas in the mortuary although staff told us cameras were not used in the fridge storage area to maintain the dignity of the deceased. Fridges were lockable to reduce the risk of unauthorised access and the potential for cross infection; however, staff told us they did not routinely lock fridges as the mortuary was secured by electronic keypads.

  Staff told us equipment needed for caring for patients at the end of their lives was readily available. Staff were able to describe the process of reporting faulty equipment.

Medicines

- We were told by staff on the wards we visited that medication for end of life care was available on the ward and was easily accessible. All nursing staff were trained to use syringe drivers as part of their mandatory medication training. Nursing staff told us their competency was checked as least annually. We reviewed evidence of the staff feedback after the training session in December 2014. Of the 4 staff who attended all said the training was 'excellent'.
- Information provided by the trust showed 85 qualified nurses and medical staff (i.e. 3% of the staff group) in the trust undertook McKinley training in 2014.
- We saw that locks were installed on all store rooms, cupboards and fridges containing medicines and intravenous fluids on the wards we visited. Keys were held by nursing staff.
- Medicine administration records were completed accurately in the patient records we looked at.
- We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation. CDs were regularly checked by staff working on the wards we visited. We audited the contents of the CD cupboard against the CD register on two wards and found they were correct.
- Electronic medicine prescription and administration records for individual patients receiving end of life care were clearly completed and provided evidence of compliance with the trust symptom control algorithm. However, prescriptions for PRN ('as required') medication did not include a maximum dosage, which could compromise the safe use of medicines.
- During the inspection we were able to observe an end of life patient being reviewed by the COPD and Palliative Care CNS. The CNS's performed the review in a sensitive, caring and professional manner engaging well with both

the patient and the family present. During the review we observed the CNS's run through the medication prescribed and the use of the syringe driver and whether the family had any questions regarding the medication and the change in their relative's condition. The CNS's were able to offer information leaflets to the family and they were able to explain to the family what changes will occur in the next few days.

Records

- The Electronic Patient Record (EPR) allowed staff to identify patients at the end of their lives which then initiated an assessment of the patients' individual needs and facilitated the development of individualised care plans for end of life care. Staff that had used it said it was useful and helped guide them in how to support a patient during the dying phase.
- We reviewed the EPR of eight patients receiving end of life care and found assessments were complete and care plans were available to give staff the information they required to deliver the care required to meet each patient's needs.
- In addition, we saw paper records located in patients' rooms. These including 'intentional rounding' charts and syringe driver administration and care records. The paper records we looked at had been completed according to trust policy.
- Weekly electronic notifications regarding the use of the end of life care plan were established as part of the response to the trust's National Care of the Dying Hospital Audit Round 4: 2014 (NCDAH) so that the leads for end of life care could monitor patients placed on the end of life plan. We were unable to review the most up to date data around the use of end of life care plans to determine whether compliance was improving.

Mandatory training

- The trust had a program of mandatory training for all staff and had achieved compliance of 97% against a target of 95% at the time of our inspection. However end of life staff training was not mandatory for all staff groups across the Trust.
- We were told by the Assistant Nurse Director for Bereavement and Organ donation that the bereavement and donation study day for all staff working in the Critical Care Unit (CCU) was mandatory. This study day includes 'Simulation Days' in brain stem testing and breaking bad news.

Assessing and responding to patient risk

- The trust used the Salford National Early Warning Score (SNEWS) for monitoring acutely ill patients to alert staff of deterioration in their condition.
- On the renal ward we were told by the manager that they had a 'cause for concern' register and monthly meetings took place where they reviewed the deterioration in patients and to discuss suitable treatment plans to ensure patients were appropriately managed. Doctors were using the predictive question 'would you be surprised if this patient dies in the next 6 months'. This allows teams to highlight patients and give the patients the necessary support required such as referring to the HSPCT or primary care teams.
- For other patients, where the progression of their illness was clearer, the amount of clinical intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. When patients were identified as at the end of their lives, monitoring was modified to ensure an emphasis on comfort. Staff told us that any changes to the frequency of monitoring was discussed with patients and their families to ensure they understood the plan of care.
- Patients at end of life continued to be monitored for comfort and safety during one to two hourly intentional rounding which was carried out by nursing staff.

Nursing staffing

- Palliative care 'link' nurses were available on individual wards. We were told by the ward managers on L4, renal and haematology that link nurses had been appointed on these wards.
- Nursing staff on the wards told us there were sufficient numbers of staff on duty to ensure the needs of patients at the end of their lives were met. Staff said patients who were very close to the end of life would have a dedicated member of staff with them at all times and there was sufficient nursing resource to facilitate this.

End of life care

- The nursing and allied health professional (AHP) element of the SHPCT for the hospital comprised: 1.0 WTE nurse consultant – (with management responsibilities across both the hospital & community setting), 2.2 WTE band 7 clinical nurse specialists, 3.8 WTE band 6 clinical nurse specialists and 0.8 WTE occupational therapist support.
- The hospital SHPCT provided a 7 day face to face visiting service (core hours 8.30am – 4.30pm) and had done so since April 2009. The weekend and bank holiday service was provided by clinical nurse specialists with access to telephone advice from palliative medicine consultants at St Anne's Hospice.
- There was a dedicated education team covering both the acute hospital and community setting which consisted of 1 WTE practice development lead, 1 WTE band 7 community end of life care facilitator, 1 WTE care home end of life care facilitator and 1 WTE band 6 hospital end of life care facilitator.

Medical staffing

- The acute hospital had two consultants in palliative medicine (totalling 1.6 WTE) delivering hospital care and community outpatient clinics.
- Specialist consultant palliative care consultants provided Monday to Friday face to face review services and the trust was actively exploring increasing this to 7 days. The clinical nurse specialist had access to consultant advice during out of hours.
- The palliative medicine consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- The palliative care consultants worked across the acute hospital, the community and with St Ann's local hospice allowing for improved continuity and management of patients who were using more than one of the services.

Major incident awareness and training

- We looked at the mortuary's capacity escalation policy and noted that code red (highest escalation) was reached when in excess of 80 deceased patients were stored. The mortuary had capacity to store 92 deceased patients. A portable refrigeration unit had been in use for several months providing additional capacity within the mortuary. Staff told us they had recently exceeded the capacity for storage and had set up an emergency mortuary storage unit in a room located along a service corridor close to the mortuary. We looked at the facility and confirmed it was secure, refrigerated and the dignity of deceased patients was maintained.

Are end of life care services effective?

The HSPC and the Bereavement teams worked well together and had developed policies and procedures based upon NICE quality standards (QS13) and the 5 'Priorities of care.' To maintain standards and ensure consistent care for patients approaching the end of their life, staff were asked to follow the guidance set out in the flow chart 'Principle of Care and Support for the Adult Dying Patient 'in conjunction with the end of life care plan and the '5 priorities of care' recommended by the Leadership alliance. The teams provided evidence based advice to healthcare professionals across all the clinical areas in the hospital.

On reviewing the electronic medical records of 9 patients entering the last phase of their live's, we found personalised end of life care plans were in place. We saw evidence that care was delivered and recorded around patients needs and preferences.

The SRFT had contributed to the National Care of the dying Audit (NCDAH) 2014 performing above average in the majority of Key Performance Indicators (KPI's). However, they were noted to be non compliant in four areas at the time of the audit. An action plan was developed and re-assessment has indicated that the service is now compliant in all but one of area.

The HSPCT have placed a Palliative Care CNS into the Emergency Admissions Unit (EAU) Monday to Friday to screen new admissions and ensure that the patients are reviewed by the SHPC Team within 24 hours or if necessary, the patient will be made clinically stable and can be discharged to their Preferred Place of Care (PPC) and Preferred Place of Death (PPD).

The HSPC team had a weekly MDT meeting (Wednesday am) of which we saw was well attended by the multi professional team,from both the hospital and community.

End of life care

Evidence-based care and treatment

- The SRFT had responded to the National Recommendations of the Liverpool Care Pathway (LCP) review by targeted work being undertaken by a 'Task and Finish Group'. In the Palliative Care Clinical Governance minutes (July 2014) it was noted that the Trust had removed the LCP from the Trust on the 30th June 2014; prior to this date, the LCP had been used but was consultant led. Ward staff confirmed that the trust was not continuing to use the LCP. This showed that the trust had responded to concerns regarding the LCP and informed staff of the replacement guidance to ensure patients were treated safely and following national guidance.
- We looked at the trust's policy 'Symptom control guidance for patients in the last days of life'. The policy in use was revised for use from June 2014 in response to changes nationally with the disbandment of the 'Liverpool Care Pathway'. The guidelines were developed for use with patients on an end of life care plan and included the medication necessary to support the management of the five symptoms experienced by patients at end of life: pain, nausea and vomiting, breathlessness, agitation and respiratory secretions. Symptom control algorithms had been agreed and implemented to support the management of dying patients. We were shown that these were available on the intranet and in all ward areas for staff.
- Clinical guidelines for pain and symptom control were used by the MDT and were previously produced through Greater Manchester and Cheshire Cancer Network Cross-cutting Group for Palliative Care and End of Life Care. The guidelines were endorsed by SRFT Medicines Management (and include management of palliative care emergencies and care of dying patients and their carers). We saw that the guideline was available in booklet form.
- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. Medical consultants from the Specialist Palliative Care Team worked across the community and at St Ann's hospice which improved the continuity of care for patients.
- To maintain standards and ensure consistent care for patients approaching the end of their life, staff were asked to follow the guidance set out in the flow chart 'Principle of Care and Support for the Adult Dying Patient 'in conjunction with the end of life care plan and the '5 priorities of care' recommended by the Leadership alliance. The 'Principle of Care and Support for the Adult Dying Patient' listed a number of core principles which were felt to be crucial to good care in the last few days of life incorporating a number of the NICE Quality Standard 13 statements. The flowchart was a checklist, which aimed to support healthcare workers as an aide memoire.
- We reviewed the medical records of 9 patients receiving end of life care; these demonstrated the HSPC team had supported and provided evidence-based advice for example, on complex symptom control and support for the patients and families as they traverse the care plan. This specialist input by the HSPC team ensured that a high level of expertise was used to ensure the best possible care was delivered to end of life care patients.
- The End of Life Care Pathway 5 was directly linked to the North West End of Life Care Model and describes the central importance of the Electronic Palliative Care Co-ordination System (EPaCCS); this being an electronic locality register to enable effective communication among healthcare professionals which was being piloted across seven wards.
- Whilst reviewing medical records we found that all patients receiving end of life care had personalised care plans. We saw evidence that care was delivered and recorded around the needs of the individuals and that wishes and preferences of the patients were documented and followed through. The Matron on H2 ward told of us of a patient who had made clear wishes around the care after death. The ward was able to follow through these wishes as they had been clearly expressed and documented. However on reviewing the National Care of the Dying Audit (Hospital) (NCDAH) action plans it was documented that 'The practice development team and clinical HSPCT should continue to promote use of the end of life care plan'. There had been an overall increase in usage of the end of life care plan in EPR from 44% in July 2014 up to 70% in Nov 2014 but this fluctuates greatly week to week (lowest 40%; highest 80%) This suggests that further work was required to embed the end of life care plan to all those patients approaching the end of their life.

End of life care

- The SRFT took part in the National Care of the dying Audit Hospital (NCDAH) round 4: 2014. The audit highlighted four areas where the organisational Key Performance Indicators (KPI) were not achieved; KPI 2 - access to specialist support for care in the last hours or days of life; KPI 3 - care of the dying: continuing education, training and audit; KPI 4 - trust board representation and planning for care of the dying; KPI 7 - formal feedback processes regarding bereaved relatives/friends views of care delivery
- In order to address the organisational KPI's that were not achieved and to improve compliance in the clinical KPI's, a NCDAH detailed action plan was developed (dated 6 August 2014) around the key findings. We saw evidence during the inspection that improvements were in the process of being actioned. For example the HSPC CNS was able to give examples where ward based training took place with generalist staff. On the neurology ward, training was given around hydration needs of end of life patients and on ward L2 bespoke training of new staff was given around advanced care planning and the end of life care plan. The nurse consultant was able to tell us that a trust board executive lead for end of life care had been appointed.
- Monthly mortality reviews took place within the MDT on a monthly basis. We reviewed the MDT education programme (2014/15) and observed that educational sessions took place at the end of the MDT. Subjects covered included the NCDAH audit, LCP response, fatigue management and review of end of life care documentation. The education sessions at the end of the MDT allowed discussions of current topical issues and kept the HSPC teams knowledge up to date and relevant to support the needs of their patients and support staff development.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care.
- On the H8 the matron told us that patient pain levels would be reviewed four hourly. If the ward team was unable to manage pain effectively the HSPC team would be called to review the patient receiving end of life care. On wards H2, haematology and B8 we found that pain medication had been prescribed and was delivered as required. We observed that electronic prescription charts were maintained.
- The HPCT team were involved in advising and reviewing the medication of patients approaching the end of life. On B8 ward the Registered Nurse (RN) told us that the HSPC team were able to give advice on the medication required to manage pain effectively as well as advising the medical and nursing teams around the medication that the patient no longer required. We were told by staff on the wards we visited that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. We found that information for patients and relatives on end of life medication was limited however we found information regarding 'giving medicines-using a syringe driver' included in the 'care and support in the last days of life.'
- We reviewed an audit of pain in palliative care: Safe Prescribing of Opioids in Adults 2014 performed by an Specialist trainee (3) doctor. The aim of this clinical audit was to evaluate the safe and effective prescribing of strong opioids for pain in palliative care for adults over 18 years of age against the NICE (National Institute for Clinical Excellence) clinical guideline 140 (2012).The findings from the audit highlighted 'appropriate opioid prescribing in terms of choice of opioid, side effect profile, route and dosing and choice depending on organ dysfunction and swallowing ability is being done well.' 'Morphine was appropriately prescribed first line and fentanyl products and patches were not used inappropriately. Patients were reviewed regularly and had the appropriate route prescribed in the majority of cases.' The audit concluded that the NICE guidance does seem to be being followed in terms of opioid dosing and choice.
- To ensure patients had adequate pain control management in place McKinley T34 syringe drivers were available to support patients on the end of life plan that required a constant dose of medication over a 24 hour period. We were told that McKinley T34 syringes drivers were available from the pharmacy within working hours. Patients being discharged to their PPC would have a community syringe driver attached prior to leaving the hospital assuring that there were no disruptions in the delivery of pain medication.
- On L8 ward the ward manager told us that for patients living with dementia or a learning disability, the 'abbey' pain tool was used to evaluate any pain the patient may

be experiencing; this was used in conjunction with clinical observations including facial, vocal, behavioural and physical signs. However we did not see the Abbey pain tool in use during the inspection.

- On the Haematology unit, the ward manager told us that any patients receiving palliative chemotherapy as a day or inpatient would initially get any pain managed by the medical team on the ward. If pain was not controlled the team would refer to the HSPCT or pain team to ensure medication was prescribed and delivered before a day patient leaves the ward.
- In the Caring of the Dying Evaluation (CODE) undertaken in May 2014, relatives were asked if they felt 'that pain was controlled in the last two days of life'. Relatives responded by saying that 48% of their relatives had no pain however 19% responded that their relative had pain all the time and 33% had pain some of the time. This suggested that more work was required to improve pain management care in the last 2 days of life.

Nutrition and hydration

- In the 'Principle of care and support for the Adult Dying Patient' and in the end of life care plan, multi professional teams were encouraged to pay specific attention to the patient's nutritional and fluid requirements. The guidance and care plan included prompts to ensure patient and family views and preferences around nutrition and hydration at the end of life were explored and addressed.
- On ward B8 a nurse told us that on admission, patients underwent risk assessments which included a Malnutrition Universal Screening Tool (MUST) assessment; this identified patients at risk of poor nutrition, dehydration and swallowing difficulties. We were told that these assessments were updated on a Wednesday and Saturday.
- Patients identified as being at high risk of malnutrition were referred to the dietician who developed food plans. The ward staff developed food record charts which were completed daily. We observed that food and fluid records were maintained in patient's intentional rounding records on the wards we visited.
- We observed on L4 and H8 that the coloured (red) tray scheme was being used to indicate those patients who needed additional help at meal times. Meal times were protected which meant staff ensured people could eat uninterrupted except for urgent clinical care. We were told that staff encouraged relatives to support family members at meal times and whilst on L4 ward we observed a family supporting their relative. However at the listening event, we received conflicting information from relatives who told us that they were not able to stay and support their relatives at meal times.
- On L4 ward we were shown nutrition board which was located in the ward kitchen; this was updated daily with the individual needs of all the patients requiring special support. All staff on the ward were able to refer to the board allowing the individual nutritional needs of the patient to be communicated to all staff.
- To improve patient's quality of life, mouth care was regularly performed on patients who were entering the final stages of their life. On L8 ward, the ward manger told us that all nursing staff were involved in delivering mouth care. This included using soft children's tooth brushes to clean patients teeth, Vaseline© or lip-salve to soften their lips and gauze swabs with water to hydrate the mouth. If the patient was able to communicate nursing staff would ask if they had a preferred juice that could be used to clean the mouth. On H8 ward we observed an end of life patient being supported with sips of water and to keep their mouth hydrated.

Patient outcomes

- We found no evidence that the EOLC Quality Assessment tool (ELCQuA) was used to support the hospital to self-assess and track progress against the NICE Quality Standards. However the HSPC team had introduced 'quality markers' to monitor the quality of care delivered to end of life patients and support the training and education programme. The 'quality markers' included assessing such areas as 'has the senior doctor responsible for the patient care identified that the patient was dying?', the diagnosis is discussed with the dying person or those important to them?, ceiling of care/ 'Do Not Attempt Cardio – Pulmonary Resuscitation' DNA CPR status was discussed?, the risks and benefits of nutrition/hydration? And if the GP was informed of the patient's death within 24 hours.
- To monitor compliance against the quality markers, an audit was undertaken by two palliative care consultants and the nurse consultant reviewing all the expected and unexpected deaths in April and October 2014 against the 'Quality Markers'. Outcomes from the audit were that

patients who were placed on the end of life care plan and are known to the HSPC team have improved compliance with the quality markers relating to nutrition, hydration and ongoing care. Areas where it was felt compliance to the quality markers could be improved included 'patients need to be identified earlier so they can be involved in their care planning, there was a need to improve the quality of conversations and how they are documented and more senior reviews are required.' This would ensure all patients were receiving consistent, safe care no matter where they were receiving their care across the wards.

- Results from the audit allowed the HSPC team to refine the end of life care plan and focus the education programme around the areas where more input was required to deliver consistent care. The audit recommended the need for clinical teams across the trust to take more ownership of the quality of end of life care delivered. Copies of the audits were sent to the clinical leads.
- The improvement in End of Life Care for Adults in 2014/15 was via a locally agreed CQUIN (Commissioning for quality and innovation) between SRFT and NHS Salford. The CQUIN for SRFT was based around Advance Care Planning (ACP) and use of the Electronic Palliative Care Co-ordination System (EPaCCS) on the wards (Communicate My Care (CMC)). The Palliative Care Consultant we spoke to told us they were actively supporting the focus on education and training of staff around ACP and use of CMC. CQUIN relating to this was on track for 7 wards with the required number of doctors in each ward area having completed CMC entries. Work around ACP and CMC was on-going and we were told the CQUIN would continue until 2016, rolling out EPaCCS across the hospital.
- As part of EPaCCS, an information standard was developed in which SRFT submitted data. The National Information Standard (ISB1580) is a core data set that enables consistent, accurate recording of the relevant facts for each person receiving end of life care. This data is collated by the National End of life Care Intelligence Network and used for local and national comparison. Information collected includes Person's details, main informal carer, GP details, medical issues and 'just in case 'medication boxes. This allows all professionals involved in the person's care to have secure access to complete and up-to-date information regarding their expressed preferences.
- The palliative care nurse consultant told us that the hospital had undertaken a pilot around the use of AMBER (Assessment, Management, Best practice Engagement Recovery) care bundles which were used to support patients that were assessed as acutely unwell, deteriorating, with limited reversibility and where recovery was uncertain. An care bundle facilitator was appointed who supported the implementation of the care bundle however when the facilitator was not available patients were not placed onto the care bundle. We were told by a palliative care consultant that the pilot's findings were evaluated and a progress report was presented at the end of life operational group however it was decided that due to the barriers to implementation of AMBER, it was decided not to continue to implement AMBER at SRFT.
- The NCDAH 2014 highlighted areas requiring improvements including the absence of mandatory and induction training around end of life care, trust board representation and planning around care of the dying, formal feedback processes regarding bereaved relatives and access to specialist support in the last hours or days of life.
- The trust performed well above the national average in the clinical key performance indicators for example in their health professionals recognising that a patient was dying, spirituality needs, review of hydration needs, number of regular patient assessments in the last 24 hours and care of the patient and relatives immediately after death to ensure dignity and respect.
- The 'Principles of Care and Support for the Adult Dying Patient' sets out the end of life plan from the point where a clinical review highlights that the patient has the potential to die within a period of hours or days or is imminently dying to the care delivered after death. Staff we spoke to were aware of the plan and what needed to be delivered to ensure high quality care at end of life.
- The end of life plan flow chart acted as an aid memorandum to staff on aspects of caring for dying patients including communication, care and symptoms, spiritual and after care. We saw evidence of the flow

chart on the wards we visited; allowing staff to ensure effective consistent was delivered to all patients requiring end of life care whether or not they have been referred to the HSPC team. We saw laminated copies of the plan on H2 ward in the medicine and doctors rooms as well as smaller versions of the plan in the end of life care trolley. Staff told us they followed the plan.

Competent staff

- End of life training was not mandatory across the trust. This had been highlighted in the NCDAH 2014. Discussions had taken place at the 'End of life care Task Group'(December 2014) on whether end of life training could be included in the induction and mandatory training however it was decided that there was no capacity to make end of life training mandatory across the hospital. To mitigate this, systems have been introduced to raise awareness around end of life care including staff being signposted to the end of life care education programme.
- The trust were also considering ways in which there was a more cohesive approach to training staff and making end of life training compulsory for link nurses. Critical care nurses completed end of life training in their induction. The palliative care nurse consultant told us that if it is highlighted that a member of staff required end of life training it could be added to individual staff members 'snowdrop' training system.
- We were told by a Palliative Care Consultant that all the consultants had completed their annual performance review (Appraisal). We reviewed a number of appraisals and the continuing professional development (CPD) records of staff members of the palliative care team; the records were up to date and completed correctly and showed that the team were highly skilled with the appropriate qualifications to treat and care for patients requiring palliative and end of life care. One of the roles of one of Palliative Care consultants was as a clinical and educational supervisor, supervising foundation year 2 doctors and GP trainees in palliative care medicine.
- The CNS's from the HSPC team were highly qualified in palliative care with several of the team having achieved their masters in palliative care or associated subjects.
- Across the hospital, palliative care (PC) link nurses were available the wards we visited including haematology, renal, L4 and the Heart Care unit (HCU). Their role through training and education was to cascade the latest information through to all staff groups within the ward to support the delivery of good end of life care. The sister on HCU, told us that the PC link nurses 'bring back best practise in Palliative Care' and are supported by 'regular emails form the Palliative Care team' and training days to keep their knowledge up to date and relevant.
- On L4 ward we were told by the ward manager that the PC link nurse had attended a recent study day at St Anne's Hospice as part of the Specialist Palliative Links across Salford Heath and Social Care (SPLASH) education programme. During the training innovative ideas and best practice in palliative and end of life care was delivered. On returning to the ward, the ward manager told us that feedback from the PC Link nurse was given to all staff groups through the safety huddles, emails and ad hoc training sessions in the ward or round the bedside.
- The ward manager on L4 ward told us there was no set level of training for link nurses. The SPLASH education programme had been planned for 2015 with study days taking place every 3 months. All health and social care staff were invited to attend these training days. We saw the 2014 training records for the SPLASH programme and in that period 98 staff had attended the training days (1% of the total workforce). However we were unable to get an overview of the percentage of staff within the hospital that had received the training in the last 3 years.
- The porters we spoke to told us that they had received training to support the movement of deceased patients to the mortuary. The 'on the job training' included the use of the mortuary out of hours to ensure that mortuary procedures were maintained. The porters we spoke to were able to describe the process in a knowledgeable manner and were able to demonstrate how they treated deceased patients with dignity and respect.
- The haematology unit manager told us that the chemotherapy nurses had completed their 'Care of patients having cytotoxic chemotherapy' course and 2 further nurses were undergoing their training. Competencies around the delivery of chemotherapy were carried out annually.

- The renal ward manager told us that all staff on the ward had undertaken 'Sage and Thyme – communications training' to support their staff in difficult situations. We saw training records that showed 141 staff members had received this training across the Trust in 2014.
- The HSPC CNS team were line managed by the Palliative Care Nurse Consultant. We spoke to one Palliative Care CNS who told us that appraisals were undertaken and were up to date .We were told by the Assistant Director of Nursing in Bereavement and organ donation, that all the bereavement team members had received appraisals and their mandatory training was up to date.
- Guidance was available on wards and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences. We were shown a laminate copy of a quick reference for all staff called 'Cultural awareness in bereavement' which included the guidance on care of the dying, post mortems, organ donation and funerals for dying people of different faiths. In the mortuary we were shown a calendar which had all the religious festivals and important days highlighted. All the staff told us that they had access to specialist advice from the chaplaincy.
- McKinley T34 syringe drivers training was available to give staff the opportunity to refresh their knowledge with regard to setting up the syringe pump ready for use and to maintain their competencies. We reviewed training records that confirmed that in 2014, 85 staff had received training. On L8 ward and the Heart Care Unit, the ward managers told us that all their staff on the wards were trained to attach and monitor the syringe drivers. On L8 ward, we were told that the PC link nurse had developed a step by step guide on the syringe driver which was displayed for easy reference.
- Three nurses worked within the bereavement centre as 'bereavement specialist nurses'. We reviewed their training records which confirmed that the nurses had studied to master's level or studied modules in bereavement.
- Three specialist nurses in organ donation (SNOD) were available within SRFT. Their primary responsibility was to manage all referrals for organ and tissue donations, region wide. The SNOD's came from nursing backgrounds and had worked as senior nurses within critical care or accident and emergency departments with a significant amount of management experience.

Multidisciplinary working

- The trust was piloting a project, 'Communicate My Care' (Electronic Palliative Care Co-ordination System, EPaCCS) on seven wards where electronic records were shared across the community, including with General Practitioners, in an attempt to improve access to health information related to the needs of patients at end of life.
- The HSPC Team held a weekly multi-disciplinary team (MDT) meeting to discuss new and current patients and agree the management plan for each patient. Management plans were recorded on an electronically stored proforma within EPR. A summary could be given to the patient if requested. The proforma used recorded information such as the patient's identity, diagnosis and their assessed needs in relation to their physical, psychological, social, and spiritual needs.
- During the inspection we were able to observe the working of the MDT. Discussions took place around discharged patients, patients who had died ensuring that referrals were made to the bereavement team, discussions around documentation regarding PPD, PPC, EPaCCS and the end of life care plan. Discussions also took place around patients 'new' to the team, pain management, team working with physiotherapists and other hospital staff including occupational therapists. We observed that all discussions were minuted and attendance sheets were completed.
- We were told that HSPC team did not comply with attendance at all MDT's however they attempted to attend the haematology, brain and lung MDT's.
- We saw evidence across the wards of MDT meetings taking place throughout the week to review patient's management plans. On the Haematology ward, the ward manager told us that MDT meetings took place every Monday and involved multi-disciplinary professionals including nursing and medical staff, pharmacist, radiologist and the palliative care team if they were available. Patients discussed and the

outcome of the discussion were placed on EPR and as this ward was a pilot site for EPaCCS, updated information on the management of the patient could be accessed by other care providers such as their GP.

- A HSPC CNS told us that close working relationships were in place with other Clinical Nurse specialists across the hospital including cancer and non-cancer specialists. The HSPC CNS was able to describe the joint work undertaken with the Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) CNS's to support the complex symptom management at end of life, reviewing patients jointly and undertaking joint audits. During the inspection we were able to observe the HSPC CNS and the COPD CNS reviewing a patient receiving end of life care. This demonstrated a multi-disciplinary approach to the management of end of life patients to ensure high quality care was being delivered.
- To support the transfer of patients from the hospital to the community teams, the HSPC CNS and the discharge liaison nurse on H2 ward were able to describe the communication flows and systems that were in place, including the engagement with district nursing teams, GP's and the community palliative care team to ensure that the community teams were well placed to deliver continuous end of life care.
- Community teams were able to access EPR and EPaCCS, which allowed them to review end of life care plans and any completed ACP. The matron on H2 told us that district nurses would visit the patients on the wards and undertake a review prior to the patient being discharged. If specialist palliative care was required at home, the HSPCT CNS would make a referral to the community palliative care team.

Access to information

- When a patient is placed on the end of life care plan ,GP's will have access to this information through the Electronic Palliative Care Co-ordination system (EPaCCS) which was currently being piloted across seven wards in the hospital including the haematology, renal and ward H2.
- We were told by the ward manager on L8 ward, as part of the ongoing discussion with patients and their relatives, the ceiling of care was discussed and documented and could be found within the end of life care plan for all staff to access. On reviewing an end of life patients' medical records on the HCU we observed that a ceiling of care was discussed with the patient and family and was documented in the patients records.
- On the renal ward we reviewed a set of patient's records. We observed that the patient's wishes had been discussed and documented along with the PPC. Staff caring for this patient in the hospital, community and GP would be able to access this information through the CMC system. The team worked closely with Primary Care to achieve a home death that was successful in this case.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust used a 'blue butterfly' scheme to identify patients with cognitive dysfunction or communication difficulty. It was recorded in patients' EPR on admission and they wore a blue wristband. A 'blue dot' identified these patients on the wards electronic boards. This meant staff were aware of patients who needed extra communication support for information or to make decisions.
- During our visits to the wards we saw and heard several occasions when staff sought the consent of patients before an intervention. We observed that staff of all disciplines communicated sensitively with patients at a level based on their communication need.
- Whilst there was a unified organisational DNACPR policy in place, there was no agreed DNA CPR policy in the wider local health community. This presented a potential problem when patients were transferred to the community to be in their PPD as the GP needed to complete the document. However, minutes of the Salford palliative 'end of life care operational group' meeting in July 2014 noted a unified North West DNA-CPR Policy (for both hospital and community) was approved at the Clinical Effectiveness Committee in 2014 but implementation of this policy had been delayed due to external factors.
- The trust had a Mental Capacity Act (2005) policy which included guidelines about patients with Advance Decisions to refuse treatment.

End of life care

- The EPR system enabled staff to complete a mental capacity assessment for patients, but we found formal assessment of patients' mental capacity was not routinely completed.
- Assessing capacity specifically for resuscitation decisions did not appear to be documented on a routine basis. The electronic DNA CPR forms made no reference to an assessment of the patient's mental capacity.
- During the inspection we were able to review the completion of DNA CPR orders. In looking at whether patients and their relatives were involved in discussions around DNA CPR orders we found that there were variations in the completeness of the forms across the hospital. Discussions with relatives or significant others were recorded in three of the six records we looked at.
- The trust's resuscitation policy set out the use of 'Do Not Attempt Cardio – Pulmonary Resuscitation' (DNA CPR) orders which stated, 'All patients are presumed to be "For CPR" unless a valid DNA-CPR decision has been made and documented and/or an Advance Decision to Refuse Treatment (ADRT) prohibits CPR'.
- DNA-CPR forms were completed on the EPR and were not printed out. Ward staff were made aware at handovers of patients with a DNA CPR and during 'safety huddles'.
- We looked at a sample of around 50 DNA CPR forms across a number of wards throughout the hospital. We found that although the DNA CPR forms were complete, mental capacity assessments and best interest decisions were not always appropriately undertaken or documented. For example, on ward L8, six patients had a DNA CPR order completed in their EPR; in three records the DNA CPR decision had not been discussed with the patient because it had been recorded that they were unable to understand. Mental capacity assessments or best interest decisions had not been recorded. In one record an MCA assessment was complete and indicated the patient had capacity but the DNA CPR decision was not discussed with them. In one record the DNA CPR decision had been discussed with the patient.
- The trust's own analysis of deaths found that DNACPR status was complete in 93% of cases (April 2014) with an increase to 96% (October 2014).
- Each individual DNA CPR order expired at the end of the patient's stay. A new DNA CPR was required on subsequent admissions. Staff told us that if a patient was transferred to the community to their Preferred Place of Death (PPD) the DNA CPR form was printed and given to ambulance staff to cover the patient's transfer home.

Are end of life care services caring?

Outstanding ☆

Staff at the SRFT provided compassionate end of life care to patients.

During the inspection we were able to observe a patient approaching end of life being reviewed by the COPD and Palliative Care CNS. The CNS'S performed the review in a sensitive, caring and professional manner, engaging well with both the patient and the family present.

The haematology manager told us that on the haematology ward the specialist haematology and Oncology Nurses develop Advance Care Plans (ACP) when it has been identified at the MDT that the patient has less than six months to live. As part of the EPaCCS pilot, the ACP can be accessed across the hospital, community, ambulance service and GP's.

All the bereavement Nurse Specialists have completed the training necessary to enable them to practice at level 2 and 3 psychological support of patients and carers. We were told that support from the bereavement nurses was also available to staff members who required support.

A bereavement counselling service was available and information about the service was available in a booklet called the 'Palliative Care Counselling Services.' We were told that the service provided emotional and psychological support for families, from diagnosis, during or following treatment and in bereavement. The service was available to carers, relatives and close friends experiencing difficulties coming to terms with the loss up to 3 years following bereavement.

End of life care

Compassionate care

- On H2 ward, the matron told us that a relative of a patient receiving end of life care was unable to come to the hospital to say good-bye. The staff on the ward arranged a phone call allowing the relative to say good bye.
- The HSPC CNS told us that a young patient had died recently on ward H2 and in order to support the family, a referral was made to the 'Clic Sargent' charity, who were able to offer the family specialist bereavement support for the next year. This illustrated that every avenue was explored by the staff to ensure that grieving relatives were supported.
- We observed the interaction between a member of staff and a patient on the haematology ward. The staff member was very supportive, with hugs, smiles and spending time talking by the bedside.
- We spoke to a patient and their relative on the HCU who told us that they were very happy with the care that their relatives had received and that they had been made welcome by the staff, allowing the relative to stay 6 nights on the ward.
- The ward manager on the haematology ward told us that they collected patient's feedback. Questions asked include 'do doctors always give understandable answers to questions? (67% responded 'yes' in December 2014) and did they feel involved in decisions? The ward manager has set time aside for discussions between doctors, nurses and the patient.
- One RN on the busy CCU expressed to us that they 'wished they had more time to talk to the families.'
- The mortuary manager told us that patients that arrived at the mortuary were prepared by the nursing staff in accordance with the 'care after dying 'policy. We were told that on several occasions identification wrist bands have been missing from the deceased patients on arrival in the mortuary but this was rectified immediately by a staff member from the ward making the identification and re issuing a name band.
- On L8 ward we were able to review the visitor's book. We observed that one relative had thanked the staff for the 'compassion shown during their relative's last days'. Positive and negative comments were discussed at the 'safety huddles'. The ward manager told us that a 'forget-me not' note was sent to grieving relatives after a death had occurred.
- The ward manager on ward L8 ward told us that if end of life patients did not have family or friends, staff would sit with patient as they approached the end of life. Nurses worked three consecutive long days, so to ensure continuity of care, nursing and support staff were allocated to the same patient and same area of the ward. We were unable to observe this during the inspection.
- The ward manager on L8 told us that they often called the bereavement specialist nurses for support. We were given two examples of when the bereavement nurse had attended the ward to support two families who were overcome with grief after the death of their relative.

Understanding and involvement of patients and those close to them

- We reviewed 9 patient records on EPR; we saw that patients referred to the HSPC team were kept actively involved in their own care and relatives were kept involved in the management of the patient with patient consent.
- The haematology manager told us that on the haematology ward the specialist haematology and oncology nurses developed Advance Care Plans (ACP) when it had been identified at MDT meetings that the patient had less than six months to live. As part of the EPaCCS pilot, the ACP could be accessed across the hospital and via community based services including the local ambulance service and GP's. This ensured that all those caring for the patient had access to up-to-date information to ensure the patient's wishes and preferences were achieved.
- On the renal ward a booklet had been developed and was available for patients to complete called 'My Wishes, My Kidney Care.' This booklet asked the patient to complete 'what is important to them and what your needs and preferences are for their care' allowing

patients the opportunity to be involved in decision making around their care needs. During the inspection we were unable to establish how many patients completed the care plan.

- The ward manager on L8 ward told us that they like to include families as much as possible in caring for their relative but only as much as they wanted to be involved. Areas where relatives supported their relatives included mouth care, which we observed whilst visiting H2 ward, eye care using damp gauze swabs and making sure the patient was supported to lie comfortably. Relatives could be asked to support relatives at meal times.
- On ward L8 the ward manager told us that some families wished to be involved in care after death however no families recently had engaged in providing after-care for their relative.

Emotional support

- Each of the bereavement nurse specialists had completed the training necessary to enable them to provide psychological support to patients and carers. We were told that support from the bereavement nurses was also available to staff members who required support. We were told by the ward manager on L8 ward that the bereavement nurse was able to support the ward staff when difficult situations develop on the ward.
- A bereavement counselling service was available and information about the service was available in a booklet called the 'Palliative Care Counselling Services'. Counsellors were members of the British Association of Counselling and Psychotherapy. We were told that the service provided emotional and psychological support for families, from diagnosis, during or following treatment and in bereavement. The service was available to carers, relatives and close friends experiencing difficulties coming to terms with the loss up to 3 years following bereavement.
- HSPC team members had completed the advanced communications skills course and several of the team, including the occupational therapist, had completed their psycho-oncology level 2 skills which supported several NICE Guidance for Oncology including NICE Advanced Breast Cancer: Diagnosis and Treatment 2009' which states that 'a palliative care team should assess all patients with uncontrolled local disease in order to plan a symptom management strategy and provide psychological support'. This highlights that the provider supported staff to gain the knowledge and skills required to meet the needs of patients requiring palliative and end of life care.
- On the Haematology ward, the ward manager told us that systems were in place to support patients during their palliative chemotherapy. If patients require support mechanisms in place include a referral being made to the clinical psychologist, nurse led chemotherapy clinic, by visiting the Mac Millan Information centre and support groups run by the haematology CNS's.
- The Chaplain is available to provide spiritual and religious support when asked by the patient/families and medical and nursing staff.

Are end of life care services responsive?

Outstanding ☆

All patients requiring end of life care could access the HSPC team who supported the rapid and fast track discharge process in order patients achieved their Preferred Place of Care (PPC) or Preferred Place of Death (PPD). The discharge liaison nurse on ward H2 told us that patients on the rapid discharge plan would be discharged to their PPC/PPD within 6 hours. Patients approaching the end of their life were given the opportunity to be nursed in a single room. Open visiting hours and free parking was available.

Comfort bags had been introduced by the bereavement team to support relatives who wished to stay overnight; these comfort bags were available on all the wards we visited. Relatives were offered 'keep sakes' of their relatives which includes a lock of hair, handprints and photographs. Relatives were given canvas 'swan logo' bags with their relative's belongings.

The Medical Certificate of Cause of Death (MCCD) were available for relatives within 24 hours or the next working day if the death occurred over the weekend.

The service engaged with external stakeholders and representatives from the local community to ensure that services remained relevant to the needs of the local population. The hospital had a faith centre which was open 24 hours every day of the week for people of all faiths. The

separate facilities in the centre included a multi-denominational Christian chapel, a Muslim Prayer room with separate male and female washing facilities, a Jewish Shabbos room and a non-denominational 'Oasis' room.

The bereavement team leader told us that the team worked closely with the police service in situations of sudden deaths, road traffic accidents and suicides across the city. Relatives were able to access the bereavement team for support.

The organ donation service is supported by 3 specialist Nurses. Between 90-100% of potential donors are seen by the specialist nurses.14 Successful donations resulted in 47organs for transplantation.

Service planning and delivery to meet the needs of local people

- As part of the end of life plan those patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. On ward H2, 13 single rooms were available to nurse patients with special requirements such as infections or those requiring end of life care. The matron told us that patients were offered single rooms but if patients wished to be nursed in a bay this would be accommodated. Privacy is maintained by keeping the curtains drawn if requested by the patient and family and the swan logo would be placed on the curtains to indicate an end of life patient was being nursed in the bay. On ward B8 we were told that single rooms were offered to patients entering the last phase of their life.
- On the haematology ward patients are nursed in single rooms with en suite facilities. The rooms have a TV and a landline telephone. The ward manager told us that an IPAD is available to any patients that require contacting friends or relatives. A folding bed was available on the ward along with reclining chairs so relatives can stay overnight.
- On L8 ward, the ward manager told us that 3 single rooms with en suite facilities are available to care for end of life patients if they wish to be nursed in a single room. No 'Z' beds or reclining chairs were available on the ward however the staff told us they would secure a mattress and make a bed up for the relatives.
- We found little evidence of family rooms on the wards however staff would give up the day room or nursing/ doctors room to provide a quiet place for relatives. On the Critical care unit (CCU) two relative's rooms were available with beds and drink making facilities for the families.
- On all the wards we visited staff we spoke to talked of the need of opening visiting hours for families who relatives were receiving end of life care. On ward H2 we observed a family by a patients' bedside at 11 am.
- On H2 ward, relatives wishing to stay overnight with their relatives had the option of staying and having a 'Z' bed or reclining chair to spend the night on. Washing facilities were not available in the single rooms for the relatives to freshen up however the matron told us that washing facilities were available on the ward for the relatives to use.
- We were told by the ward manager on L8 ward that relatives of patients receiving end of life care would receive free parking. On all the other wards we visited, staff confirmed that free parking was available to relatives visiting end of life patients.
- Comfort bags had been introduced by the bereavement team to support relatives who wished to stay overnight but did not have any items to freshen themselves up. These comfort bags were available on all the wards we visited. The comfort bags contained soap, tissues, tooth brush and toothpaste. The ward manager on L4 told us that staff replenishes the comfort bag using funds from charitable funds.
- As part of the end of life care plan relatives were offered 'keeps sakes' of their relatives which included a lock of hair, handprints and photographs. On wards H2 and L8 staff were able to demonstrate the end of life care box that held all the 'care after death' items. We were shown 'Nekoosa' wipes to produce hand prints, small bags to place hair locks in, cameras to take photographs, information leaflets and swan logo paperwork and bags. On ward B8, a nurse told us that they had performed handprints for 13 relatives recently and on the heart care ward staff confirmed they offered families 'keep sakes'.
- The HPC CNS reviewed patients depending on their needs offering support and reviewing care needs. Patient contacts range from 15-60 minutes depending

on the need of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke to medical teams and carers.

Meeting people's individual needs

- There was no dedicated specialist palliative care ward. People reaching the end of their life were nursed on the main wards in the hospital. Patients were cared for in side rooms on wards to offer quiet and private surroundings for the patient and their families; we saw this in practice when we visited the wards.
- Although there was no electronic system that alerted staff if a palliative care or end of life patient had been admitted, the HSPCT placed a palliative care CNS into the emergency admissions unit (EAU) Monday to Friday to screen new admissions and to ensure that relevant patients were reviewed by the SHPC Team within 24 hours, or if necessary, the patient was to be made clinically stable discharged to their preferred place of care (PPC) or preferred place of death (PPD). The palliative care nurse consultant told us that further plans were in development to extend this service to the elderly care wards and respiratory ward. A business case had been developed and was at the Divisional Operational Board for approval. This was confirmed in the minutes of the 'Task and Finish Group' minutes 2014.
- The HSPCT team, in 2013-14, were referred 1,417 patients and undertook 5,000 contacts. Of this number, 687 patients had a diagnosis of cancer (48%) and 730 patients had a non-cancer diagnosis (52%).The HSPC team were supporting a high percentage of patients with a non-cancer diagnosis which was well above the national average of 28% which highlights the SHPC team commitment to supporting all patients approaching the end of their life no matter the diagnosis.
- The bereavement team had introduced a symbol that was used across all clinical areas to identify patients who were receiving end of life care. The 'Swan' logo had been developed and was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed in a patient being nursed in a bay. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible. The swan logo was placed in the bereavement literature.
- The bereavement team had introduced a canvas bag with the 'swan logo'. This was used by the nursing staff to place the deceased patient's belongings into. By using the bag this highlight's to all staff that the relatives have suffered a recent loss and may require extra support. It was more dignified to receive the deceased patient's belongings in this way rather than in a plastic bag.
- We were told that patients at end of life would be assessed by the medical and nursing teams to develop individualised care plans to meet their individual needs. On the end of life care plans reviewed we observed that the PPC was discussed with the patients and those close to them was documented in the care plan.
- All patients within the trust who required end of life care had access to the HSPC team. On L8, the ward manager told us that three patients were receiving end of life care on the ward. Of the three patients only one patient required input from the HSPCT who provided advice and support on complex symptoms. The remaining two patients were managed by the ward medical and nursing team.
- We visited the mortuary where we viewed two viewing suites where families can come and spend time with their relatives. The doors of the viewing rooms would display the name of the patient during the viewing to ensure visitors were aware and did not enter the wrong room. Appointments could be organised through the bereavement office or mortuary and were available Monday to Friday throughout the day.
- We observed that the viewing suites were decorated in neutral colours with no religious symbols in place however the mortuary manager told us that they could accommodate all religions. The mortuary manager was able to describe the systems that were in place to accommodate all night vigils, where for religious reasons; relatives need to stay with their relative. This highlighted the respect the mortuary staff shows to the different cultural, religious and spiritual preferences of patients they care for.

End of life care

- Information leaflets for families whose relatives were receiving end of life care were available and were given out by ward staff. The information leaflets include 'Care and support in the Last Days of life', 'Information for bereaved relatives' and 'Bereavement support'. Ward staff we spoke to told us they would give relatives these leaflets and a brief overview of the information making themselves available for any questions relatives may wish to ask. We also saw on the Renal Ward that information booklets were available to patients with kidney disease including 'Supportive Care for your Kidney disease'. All leaflets were available in different languages and format on request.
- The 'Pam Woods Suite' (bereavement centre) carried out the administration of a deceased patient's documents including the Medical Certificate of Cause of Death (MCCD)and belongings, providing practical advice and signposting relatives to support services such as counselling services and funeral directors. The suite contained 3 consulting rooms which meant that interviews of the bereaved relatives would take place with the upmost privacy.
- The Bereavement team told us that systems were in place for the quick release of deceased patients, if required for religious reasons. We were given an example where a patient died at 6pm; the deceased patient was released from the hospital by 8pm. Staff stayed behind to support the process.
- We were told that MCCD are available for relatives within 24 hours, or the next working day if the death happens over the weekend. We were told on EAU that following the death of a Jewish patient the MCCD was signed by the doctor on the unit which allowed the quick release of the deceased person.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- Families were offered the opportunity to accompany their deceased relative to the mortuary doors on a bed accompanied by two nurses. One member of staff leads the way (as a 'lookout'). Whenever possible the service corridors would be used however inevitably some corridors were public. Mortuary staff told us it happens about once a week. Nursing staff told us most people choose not to do it and the concealment trolley is used.
- We were told that the introduction of this service came from relative feedback – people requested the opportunity to do it, however we were unable to confirm this during the inspection. We did not see a policy relating to transferring the deceased in this way. We do not know how it was implemented e.g. how were staff were prepared for this (i.e. it's different experience placing a wrapped body in a concealment trolley to being able to see the dead person.) We were told about one member of portering staff that several of the porters were distressed by the experience and were exempt from supporting the transfer in this way.
- We were shown how deceased patients left the hospital either by undertakers or by family. The area outside the mortuary was not overlooked by any wards nor did the road have public access. This meant that deceased patients could leave the hospital discreetly.
- The bereavement team leader told us that the team work closely with the Police Service in situations of sudden deaths, road traffic accidents and suicides across the city. Relatives are able to access the bereavement team for support. We were told that the Police often ring the bereavement team for advice even when the deceased person will not be coming to SRFT.
- Alter the finding of the NCDAH where it was highlighted that no feedback was received by the bereavement and Palliative Care team a CODE questionnaire was developed and given to relatives in May 2014.We were told that the questionnaire was photocopied and sent to the appropriate medical team in order that they can take ownership of the comments and inform changes in the delivery of end of life care. We reviewed the results from the questionnaire and the results were positive in the majority of the questions for example 'the bed and surrounding environment provided adequate privacy? 62% strongly agreed and 28% agreed' and the confidence and trust of the nurses who were caring for their relative? 86% strongly agreed and 14% agreed.
- For patients and relatives of patients affected by cancer, the McMillan Information Centre, which is opened Monday to Friday 10-4pm at present, can offer

emotional, financial and practical support and information .Although 95% of their work is with cancer patients, the team told us that they do not turn away patients and relatives who do not have cancer. The centre is able to refer patients to the 'Willow Foundation' which is a charity that provides holidays and special days to people between 16-40 years old who are seriously ill. Patients with complex financial and social needs can be referred to the Citizen's Advice Bureau for help which may include grants.

- We spoke with Assistant Director of Nursing who told us that the organ donation service is supported by 3 specialist Nurses, one nurse covering Accident and Emergency and 2 nurses covering CCU. System were in place to offer patients and relatives the opportunity to donated organs and tissues. We were told that between 90-100% of potential donors are seen by the specialist nurses. We reviewed the Tissue Donor Referral and Donation report April 2014 to January 2015 and saw that '57'contacts were made. We saw that 14 Successful donations resulted in 47organs for transplantation.
- The hospital had a faith centre which is open 24 hours every day of the week for people of all faiths or none. The separate facilities in the centre includes a multi-denominational Christian chapel, a Muslim Prayer room with separate male and female washing facilities, a Jewish Shabbos room and a non-denominational 'Oasis' room for people of all faiths or none. The chapel can accommodate several beds if it is necessary to transport patients on their beds for services. The Oasis room is between the chapel and prayer room and folding screen walls provide an adaptable space to increase the size of the chapel or prayer room for services as needed.
- The trust did not have one religious or spiritual policy, but the remit fell within other policies, for example, Principles of care of the dying patient. Staff told us they follow national guidelines for chaplaincy.
- The Chaplaincy was served by two full time Church of England chaplains, two Free Church chaplains who worked a total of three days, a full time Catholic priest supported by a nun and a female Muslim chaplain who worked three hours a week. A nominated Rabbi provided services to the hospital Jewish community as required and an Imam visited for Friday prayers.
- During our inspection we met four members of the chaplaincy team. Chaplains are available 24 hours a day easily contactable through the hospital switchboard for out of hours visits and a 'flowchart' on the wards directs staff to the numbers to call. Staff contact chaplains by telephone or in person to refer patients or ask them to visit.
- The chaplaincy had 22 regular volunteers who visited the wards. Volunteers identified and offered initial pastoral support to end of life care patients but would also refer the patient to the chaplaincy. Chaplains 'occasionally' sat with dying patients if it was requested.
- A range of services took place regularly in the faith centre including daily ecumenical midday prayers for the Christian community, Friday prayers (two sessions) for the Muslim community and Roman Catholic mass five days each week. Written information about chaplaincy services was not available in leaflet form because it was in the process of being updated.
- Chaplains told us they were involved in the development of the end of life care policy. They work closely with the hospital bereavement team and attend organ donation MDT meetings.
- Chaplains are involved in delivering regular training to staff including monthly bereavement study days, equality and diversity training (4 sessions in the last 12 months) and ad hoc training for example, 'Meeting the needs of the Jewish community'.
- The chaplaincy provides services tailored to patients' individual needs. For example, they have conducted baptisms, marriages and 'celebrations of love'. They conduct the services for contract funerals of deceased patients who have no relatives.
- The Shabbos room is supported by the local Jewish community and is stocked with kosher food.
- The prayer room is laid out with prayer mats and has screening to separate male and female attendees. Head coverings are provided for people who want them.
- The bereavement office was open Monday to Thursday 8.30-4.30 pm and on a Friday 8.30-3.30pm.

End of life care

- Chaplaincy cover was provided 24 hours per day. Outside the hours of 9am and 5pm an emergency service was provided. The Chapel and multi-faith room was open 24 hours a day for prayers.
- During long chemotherapy sessions patients are supported with regular refreshments and food.

Access and flow

- We were told that systems were in place to facilitate the rapid and fast tract discharge of patients to their PPC or PPD. The HSPC CNS explained that a multi professional approach is in place, which includes a discharge liaison nurse to ensure that patients are discharged in a timely manner with all the necessary support and equipment in place. The discharge liaison nurse on ward H2 told us that patients on the rapid discharge plan will be discharge to their PPC/PPD within 6 hours. The fast track discharge plan (those patients with approximately 3 months to live) will be discharge within 24-48 hours.
- We reviewed the data submitted to NHS Salford in the HSPC team service specification report for the end of June 2014; patients who were successfully discharged home on the rapid discharge plan were seven, of which seven were successfully discharged within the 6 hour window. On H2 ward the discharge liaison nurse told us that patients who live in the Salford area, all discharges take place within a 6 hour window. We were unable to confirm this information during the inspection as this data is not audited officially.
- To support the rapid discharge plan partnership working was in place with the Ambulance service. A separate ambulance number for these patients has been set up, where the ambulance service prioritises these patients. The discharge liaison nurse on H2 ward told us that they recently had two patients discharge on the rapid discharge plan, the ambulances appeared 20 and 30 minutes after the calls were made. This responsive approach by the ambulance service ensures patients achieve their PPC/PPD in a timely manner.
- In 2013/14 a CQUIN was in place with NHS Salford around achieving patients PPD. This has continued in 2014/15 as a Greater Manchester KPI. SRFT had to identify end of life patients PPD and subsequently achieve it. Data we reviewed for the end of quarter 2 (September 2014)was that out of 151 patients where the PPD was documented, the PPD was achieved in 137 patients achieving compliance of 90.7%.Some of the reasons the PPD was not achieved was sudden deterioration in their condition, no available hospice bed and patient changed their mind.
- As part of the 'care after death policy' deceased patients are expected to be transferred to the mortuary within a four hour window. The hospital monitor how timely deceased patients leave the ward.
- The hospital HSPCT aimed to respond to requests to see 90% of patients within 24 hours. Referrals to the HSPCT can be by self-referral and referral by professional groups (telephone, secure haven fax and secure electronic ward order). Across the patient plan a Palliative Care Key Worker will be allocated to the patient. The patient will be informed of the name of the Key Worker, their contact details and receive an outline of their role. We reviewed quarter 1 data presented by the Nurse and Medical Palliative care consultants to NHS Salford in August 2014, which indicated that 85% of patients with pain symptoms were seen within 24 hours of a referral being made. However only 47% of patients with other symptoms were seen within 24 hours. In the complex last days of life care 81.2% were seen within 24 hours of referral. The HSPCT were questioning the data and had requested further scrutiny, we were not given further information as to whether the data changed or remained the same.
- The trust had a target response time of 72 hours for the HSPC team to respond to referrals for placement advice and psychological or spiritual support. The trust's target of 90% of patients to be seen within the time frame was met or exceeded in quarter 1.

Learning from complaints and concerns

- We were told by the Palliative Care nurse consultant that the bereavement team are proactive in managing complaints by picking up an issues that exist with relatives at the bereavement interviews that take place when the relatives pick up the Medical certificate of the cause of Death (MCCD).The bereavement team will address any issues early on with the clinical teams and resolve where possible before a formal complaint is made. However during the listening event two families we spoke to whose relatives had received poor end of life care were not happy with the complaints process in place.

End of life care

- In the minutes of the end of life task and finish group (December 2014) it was suggested that the bereavement team were looking at placing a comments box within the centre and by introducing a bereavement tree they would ask the question ' if you could change one thing about end of life care what would it be?' This would allow relatives thoughts and opinions to contribute to improving the quality of care.
- The Palliative Care Nurse consultant told us that no complaints had been made against the HSPC team in the last year. The Assistant Director of Nursing of bereavement and organ donation confirmed that the bereavement centre had received no complaints in the last year in relation to the service they deliver.

Are end of life care services well-led?

Outstanding ☆

A detailed action plan was in place in response to the NCDAH; A Work Programme for the Specialist Palliative Care MDT for 2014/15 was in place and was being implemented across the Trust.

A 'Palliative care clinical governance' meeting took place every two months with attendees from the palliative care teams from both the acute and community parts of the trust. Operational processes were discussed within the group, including areas such as complaints, risk register, audit, quality measures and mandatory training.

The executive Nurse has been appointed as the nominated board lead for the development of and provides representation at trust board level for care of the dying. Non-Executive directors have been appointed for end of life care and complaints. There was a non-executive chair for the Bereavement and Donation Committee. There was good leadership of the HSPC team led by the Palliative Care Consultants and the Consultant Nurse.

The bereavement service had good leadership led by the Assistant Director of Bereavement and Organ Donation.

Vision and strategy for this service

- The Trust did not have an updated version of an end of life strategy. The last strategy covered a period up to 2014.
- We reviewed a detailed action plan in response to the NCDAH; 2014. The action plan detailed the key areas the trust aimed to make improvements around the delivery of end of life care in 2014/15. This included areas in both palliative, end of life care and bereavement care. The trust took the opportunity to develop an action plan that not only covered the areas where the organisational key Performance indicators (KPI)'s were not compliant but took the chance to improve their compliance in the delivery of the Clinical KPI's, most of which the trust performed above the national average. A work programme for the Specialist Palliative Care MDT for 2014/15 was in place and was being implemented across the trust.
- We saw that many areas of the action plan were being implemented and were compliant at the time of the inspection illustrating that teams involved were addressing areas for improvement in a timely, well cohesive manner. Following receipt of the NCDAH national and site-specific report, the findings were presented to the trust executive quality and safety committee and at respective divisional clinical effectiveness meetings; an action plan for the trust was completed incorporating quarterly reviews (last review 30 November 2014).
- The palliative care consultants contributed to the trust's response to the independent review of the Liverpool Care Pathway, 'More Care, Less Pathway' (2013) and 'One chance to get it right' (2014). The LCP was withdrawn from the trust on 30 June 2014 and was replaced with 'Principle of Care and Support for the Adult Dying Patient' in conjunction with the end of life care plan and the '5 priorities of care'. Quality markers for use with the end of life care plan were introduced to monitor the quality of care across all ward areas.

Governance, risk management and quality measurement

- The palliative care team had a risk register with one risk remaining on it regarding capacity and increased clinical workload for the team. The risk had an action plan and was set to be reviewed again in February 2015.
- A 'Palliative care clinical governance' meeting took place every two months with attendees from the Palliative care teams from both the acute and community parts of the trust. Operational processes were discussed within the group, including areas such

as complaints, risk register, audit/quality and mandatory training. In response to the review of the LCP, an end of life 'Task Group' was established to develop the Trust's response to the recommendations. We reviewed the minutes from the 'task group' areas the group; these consisted of developing and operationally managing actions which were required to embed a culture of change, improvement, education, learning and standards of consistently high levels of clinical performance.

- We were told by the palliative care medical and nurse consultant's that an end of life operational group took place bi-monthly. We were unable to establish who sat on the group or how the group took forward end of life care issues. We were told that the on-going attendance was poor.
- The SPC Team consisted of a governance lead (includes clinical audit), a palliative care consultant and the consultant nurse (Hospital and SRFT Community) .We saw that the MDT undertook a variety of roles which included: continuously updating its clinical governance programme, regularly reviewing and updating guidelines, protocols and patient plans for all key service areas, ensuring regular appraisals, continuing professional development and compliance with mandatory training for all staff and making regular external clinical supervision available. The team also considered reports on patient experience, clinical effectiveness and risk management effectiveness and ensured appropriate action plans were developed and implemented.
- The Executive Nurse had been appointed as the nominated board lead for the development of and trust board representation for the care of the dying agenda. This appointment was made as part of the NCDAH 2014 action plan. Non-Executive directors had also been appointed for end of life care and complaints. End of life care was not discussed regularly at the trust board meetings. There was a non-executive chair of the Bereavement and Donation Committee.

Leadership of service

- There was good leadership of the HSPC team led by the Palliative Care Consultants and the Consultant Nurse.
- The bereavement service had good leadership led by the Assistant Director of Bereavement and Organ Donation. SRFT was a member of the 'Royal's Alliance Bereavement and Donor Service'. This is a nurse led innovation transforming practice across SRFT, Royal Bolton Hospital NHS Foundation Trust and Wigan, Wrightington and Leigh NHS Foundation Trust with the purpose of providing excellent end of life care for all. Multi-disciplinarily team members from porters to consultants and coroners achieve excellence in care, delivered with care and compassion by contributing to the development of policies and procedures to support patients and relatives through end of life and bereavement.

Culture within the service

- The Assistant Director of Nursing and all the members of the bereavement service were passionate about supporting both families and staff in end of life care.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- We spoke to staff about how supported they felt in their roles. They all described how they felt supported and told us how approachable there managers were.
- We asked the mortuary staff whether the staff working in their department felt a sense of belonging to the wider hospital team. They told us that they had lots of contact with non-mortuary staff and contributed to the development of the end of life policies. There were frequent visitors such as the chaplains, porters and undertakers. They were able to see where their work fitted into the provision of end of life care services.
- All the staff we spoke to spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility and this was very evident in the HSPC team and the bereavement team in their patient centred approach to care.
- Across the wards we visited we saw that the HSPC team and bereavement team worked well together with nursing and medical staff and there was obvious respect between not only the specialities but across disciplines.

End of life care

Public and staff engagement

- To ensure public and patient representation was established and maintained within the Trust a member of the public was appointed a member of the End of life Steering Group.
- The bereavement team were involved in a public campaign to increase the awareness of tissue and organ donations.
- The bereavement team produced a newsletter called 'bereavement matters' where they engaged and kept people involved in bereavement matters across the trust.
- SRFT were involved in the National Dying Matters Coalitions initiative in 2010, 2011 and 2012 which were organised and delivered by the Palliative and End of Life Care teams.

Innovation, improvement and sustainability

- We were told the trust was actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. The Trust had piloted the use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB) which were used to support patients that are assessed as acutely unwell deteriorating, with limited reversibility and where recovery is uncertain however it was decided not to continue to implement the ACB after the pilot. Other improvement areas include Advance Care Planning (ACP), EPaCCS, rapid discharge plan, meeting the priorities for care of the dying person and effective care after death including bereavement and mortuary service. During the inspection it was evident that the teams across all the clinical areas were actively involved in implementing this service improvement programme.
- The SPC team were actively involved in service improvement projects and undertook audits to monitor the quality of end of life care across the Trust.
- Innovative work undertaken included the access to seven day Specialist Palliative Care for SRFT since 2009 (only 21% of trusts deliver this nationally). The trust has participated in all 4 rounds of the NCDAH and the trust was described as above the national average for 9 out of 10 Clinical KPI's. The bereavement care delivered across the trust and the trusts awareness around cultural needs of the population were well met by the HSPC, bereavement and the chaplaincy teams.

Outpatients and diagnostic imaging

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

Information about the service

Salford Royal NHS Foundation Trust saw 375,667 patients in outpatients (OPD) last year.

As part of this inspection we visited most outpatient areas at the acute hospital site to speak with patients and relatives. We also spoke with staff and departmental managers. Information provided by the trust was reviewed and corroborated for accuracy and then used to inform our judgement.

The main OPD ran clinics in general surgery, breast, colorectal surgery, Ear nose and throat (ENT), oral surgery, orthodontics, dermatology, MOHS (micrographic surgery),gastroenterology, haematology, cardiology, neurology, neurological surgery, head and neck, urology, sexual health and respiratory medicine.

There were further OPD areas for trauma & orthopaedics which included a fracture clinic. There was also a renal outpatient department which provided outpatient care to people with kidney failure living in the west sector of Greater Manchester.

Summary of findings

The premises were mostly appropriate for the service they were providing although the main OPD required an upgrade in design; the fabric of the building provided challenges for staff as the ceiling occasionally leaked from the soil pipe.

Where issues around capacity had been identified the trust had responded to reduce the impact on patients by providing extra clinics. However there were improvements to be made around waiting times in some specialities. There was scope for a more consistent and sustained level of achievement in meeting targets for referral to treatment times on the 18 week non-admitted pathways.

There had been an issue around the reporting times in magnetic resonance imaging (MRI) scanning. Although staff had taken steps to mitigate a build-up of unreported scans, the measures taken could not be sustained in the long term with existing staffing levels and methods of working. The trust was in the process of reviewing the staffing levels and productivity in the radiology department.

There were concerns during our inspection around the safety of staff working alone in the outpatient ambulance wait lounge and the ability of staff to ensure that patient care needs were met in the lounge when they working alone. However, this issue was raised during the inspection and service managers had mitigated the risk immediately following our inspection.

Outpatients and diagnostic imaging

Staff were kind, attentive and spent time ensuring patients understood what their appointment involved and what their treatment plan was. Where necessary, people were assisted around the department.

Leadership at all levels was visible and engaged with operational staff. Staff reported feeling supported and encouraged to innovate.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Although some OPD areas had been refurbished recently the main OPD environment presented challenges for staff particularly relating to leaking roof areas and sewage leaks from a soil pipe. The Trust planned to refurbish the main OPD although no dates for this refurbishment were in place at the time of our inspection.

Equipment was readily available and staff were trained to use it safely.

There were effective systems in place, supported by adequate resources, to enable the department to provide good quality care to patients attending for appointments. We spoke with staff of all grades and disciplines across the Trust outpatient areas and were told that the majority felt the department was adequately staffed to meet patients' needs.

Incidents

- During the last year there had been one serious incident reported in OPD which related to a late diagnosis. There were no never events reported. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Trust policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- Staff completed an incident form which once submitted went to their line manager who reviewed the incident and reported on the actions that they had taken to mitigate a reoccurrence of the incident.
- We saw that root cause analysis (RCA) investigations were performed for serious incidents. We looked at an example of an RCA and saw that it was comprehensive

and detailed with associated action plans. We followed up on an RCA action plan and found that the action plans had been implemented and that staff were made aware of the incident and the associated learning.

- Staff told us they had a system in place to ensure they received feedback when they reported an incident. We looked at minutes of staff meetings and noted that there was a standing agenda item where reported incidents and their outcomes were discussed with OPD staff. Staff also told us that they received feedback from incidents during their daily department huddles.
- Managers told us that they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.
- The radiology department used the hospital electronic incident reporting system as well as having a service level agreement (SLA) with the Christie Medical Physics and Engineering (CMPE) who oversaw any radiology related exposure incidents. After an exposure incident, additional information was sent to the CMPE. They then had up to two weeks to respond to incidents. The Radiology Business Manager told us that the reporting mechanism had recently changed in (CT) scanning. The tolerance in reporting had decreased which has meant that there has been an increase in the number of incidents reported.
- We were given an example of a recent incident in radiology. On the request form it was highlighted that the patient had a pacemaker in place. The patient was unable to have an MRI so a CT lumbar spine was performed instead. It was found that the patient did not have a pacemaker in place and therefore had received an inappropriate radiation dose. We were told the patient was made aware of this incident. The investigation into the incident was ongoing at the time of our inspection.
- Feedback from incident reporting in radiology was managed through bi monthly radiology clinical governance meetings. All staff were invited to these meetings. Where staff were covering the clinical areas and unable to attend, the meeting minutes and presentations were emailed to them. During the meeting, incident reporting was discussed. We saw the minutes of these meetings.
- The Radiology Business Manager attended divisional meetings to look at learning from serious incidents. The monthly radiology clinical governance sub-committee which included clinicians, secretaries, radiographers and management discussed incidents, policies and procedures, risk register items and ratification of policies, complaints and compliments.

Outpatient Assessment and Accreditation System and Safe (OPAAS), Clean and Personal Care, every time (SCAPE)

- The Trust held an assessment and accreditation scheme where each ward area was scored under a number of criteria.
- OPD had scored an Amber rating on the OPAAS scheme at their first assessment. As a result of this the department had devised an action plan to address the areas which required improvement.

Cleanliness, infection control and hygiene

- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each OPD area, and documented in the annual clinical governance report.
- The staff we observed in the OPD were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows. We observed staff in the main OPD washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- Each area displayed their hand hygiene results for the previous month on patient information boards. Over the period of a month the hand hygiene practice of 100 staff from different staff groups were observed across all areas of OPD. The results for each OPD area ranged from between 95% and 100% compliance with hand washing techniques.
- Staff working in the OPD had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- Clinical areas were monitored for cleanliness by the facilities housekeeping team and results were displayed on patient information boards in each area of OPD. Housekeeping staff could be called to carry out additional cleaning, where staff felt it was necessary. Cleaning audit scores met with expected cleaning standards, with audit scores ranging between 96.9% and 100%.

- Where areas were found to be below the expected cleaning standards during an audit, a recheck sheet was completed highlighting the area of concern. Cleaning staff were expected to correct the issue within one hour. We noted that there were no records to demonstrate that staff had addressed the areas of concern highlighted during audits. We raised this with the Housekeeping manager at the time of our inspection.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that equipment and rooms had been cleaned.
- The equipment that we saw was in good repair; we noted that the green labels the Trust used to indicate that equipment had been cleaned were being used.
- In one area of OPD we found that the dirty utility on a public corridor was unlocked. This dirty utility was used for the storage of sharps bins that had been delivered from the community. Clinical waste was also stored in this area ready for collection. Hazardous waste must be stored securely. This meant that in this instance hazardous waste had not been stored in line with relevant legislation (Environmental Protection Act 1990/ Hazardous Waste Regulations 2005).

Environment and equipment

- Some areas of main OPD were carpeted which was not an easy to clean surface; parts of the carpet were stained. The Department of Health (DOH) . This includes all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances'. The OPD manager was aware of this issue and was hoping to replace the flooring once funding was agreed.
- In the Orthodontic OPD there was a defective joint area in the flooring in surgery 2. HTM 01 05 (Health Technical Memorandum decontamination in primary care dental practices) 6.46 states that all surfaces and equipment should be impervious and easily cleanable. Work surfaces and floor coverings should be continuous, non-slip, and where possible joint-less. It was also noted that cabinets which stored equipment in the Orthodontic OPD needed replacement as they were wooden, with scratched surfaces, which were hard to clean and could collect dirt and bacteria.
- In the Orthodontic OPD X-Ray room (G44) one wall had been discovered as being covered with mould during infection control auditing. The wall in this room showed water damage from a leak from the ceiling which we were told had had also penetrated the x-ray equipment.
- Other areas of OPD had experienced water leaks through the ceiling. A staff member described their experience of finding a ceiling bulging because of a burst pipe and on 3 occasions, over a 3 month period, the leaks involved soil pipes. Another staff member described one of these occasions when raw sewage was in the corridor and the immediate part of the building was closed whilst facilities staff cleaned the area.
- Some call centre staff made reference to a unpleasant experience in relation to the soil leakage and their working environment, where they had been asked to work in the call centre following a sewage leak. One staff member said, "Conditions in here are bad. The carpets are bad, sewage leaks happen a lot, every other week. Last time it happened I was told I could move to another desk in the same room – not nice".
- The trust was aware that there were issues with the environment in the main OPD as they had been escalated. They were planning to renovate this area and were currently looking at how clinics could be accommodated during a refurbishment. There were no dates for when refurbishments would happen but this issue was on the Facilities risk register.
- Following the inspection, we asked the trust to provide us with a copy of the most recent risk assessments in order that we could determine how the risks associated with the leaks were being mitigated to ensure patient and staff safety had been sufficiently assessed. The trust advised that patients had not been exposed to any risk as the areas were closed to patients' when a leak occurred. In addition, there had been no evidence that staff safety had been compromised. However, there had been no risk assessments completed following the leaks to ensure that risks had been assessed in a robust manner.
- Whilst the trust was unable to provide risk assessments at the inspection, they provided us with a copy of the issue which had been logged on a local risk register. In addition, the trust took immediate steps to compile risk assessments once this had been highlighted as an area

for improvement. Furthermore, whilst actions and mitigations were not documented comprehensively in conjunction with robust risk assessments the trust were able to evidence that actions had been taken.

- A toilet in the main OPD had been renovated with the intention of it becoming a dermatology procedure room. The area was small with no ventilation or natural light. Patient access was limited with inadequate space for patients requiring mobility aids. Department leads were aware of this and the room had been left unused to ensure adequate environmental risk assessments took place.
- All mobile electrical equipment that we looked at had current Portable Appliance Testing (PAT) certification.
- We saw that the resuscitation trolley was checked and maintained ready for use in an emergency.
- From observation in the OPD we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacement equipment was provided, when necessary.
- In radiology, risk assessments were carried out for all clinical areas bi-annually; supported by CMPE. CT risk assessments were carried out when new equipment was delivered, if a new technique was introduced or if there was a sudden increased use of the equipment. Adjacent areas were also risk assessed to ensure the radiation dose was not above permissible levels. We were given an example of where a surgeon requested an x-ray during a surgical procedure. As the room had not been risk assessed for the equipment the examination could not be performed.
- The MRI suite was restricted to authorised personnel only. The MRI suite (2 scanners) in Radiology 2 had a reception area where the patients and relatives could wait. Access to the scanning sub-waiting area was through a coded door escorted by a member of staff. Doors to the scanners had regulation warning signs on the door. Doors could be locked during times where no authorised personnel were available and during scanning.
- Lead coats were available outside the examination rooms in Radiology 2 including the interventional room, CT and bariums. We noted that varying thicknesses of lead coats were available and clearly identified. We saw evidence that the lead coats were regularly cleaned and checked to ensure the lead within the aprons was not damaged.

Medicines

- Medication refrigerator temperature checks were being completed by staff in line with Trust policies. Temperature records that we looked at were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range.
- In the main OPD prescription pads were checked out to areas of OPD at the beginning of each day and recorded as checked back into a secure cupboard at the end of each day. This process was in place to provide assurance that all used prescriptions could be accounted for at the end of each clinic and we were advised that to date no prescriptions had been unaccounted for. However, during clinic hours, pads were stored on nurse's stations in each OPD area and on three occasions during our inspection we were able to handle prescription pads that had been left unattended by staff. This meant that access to prescription pads was not being managed safely as patients or visitors to OPD could remove them without challenge.
- Prescriptions administered in OPD could only be used at the commercial pharmacy on site. Some patients complained to us about the time it took the pharmacy to dispense their prescription. We noted long queues at the pharmacy during our inspection with people waiting 40 minutes on one occasion.
- Patient leaflets relating to medications were available in each area of OPD.
- We were shown an RCA following an incident reported for medication administration. The incident was recorded when a patient was administered with a steroid injection that they had not consented to. The RCA was comprehensive and detailed and contained an associated action plan.

Records

- Health records were stored electronically and staff were given passwords to access these records only when they had been trained in the safe use of the system.

- As a result of the electronic health record system, staff reported very few issues with health records not being available for clinic. The Trust reported that as a result of the electronic system 0.0001% of patients were seen without access to their Health Records.
- At our listening event a patient told us that they had had issues with health records not being available during their clinic appointment. As this did not correlate with the results above, when we spoke to staff they explained that this only happened on very rare occasions at weekend clinics when locum staff may not have full access to patient health records. We were told that where staff recognised that this may occur, they would proactively ensure paper records were printed to be reviewed during the appointment.

Safeguarding

- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the Trust safeguarding lead was and how to contact them.
- 100% of staff working in the OPD had completed mandatory safeguarding vulnerable adults training, and 100% had completed child protection training to level 2. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust safeguarding policies on the intranet.
- An OPD staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- The Trust had a chaperone policy that was followed by the OPD staff.
- The Trust had a whistleblowing policy that was known to staff that we spoke with working in the OPD.

Mandatory training

- Staff were encouraged to take responsibility for completing mandatory training. Where staff were close to going out of date with their training, reminder emails would be sent to them along with their line manager.
- Trust policy dictated that when staff became out of date on any aspect of their mandatory training they would be suspended without pay until they had ensured that they had completed training. The trust target for mandatory training was 95% of staff being up to date. This was to take into account staff on long term sickness or maternity leave.
- Records showed that 97.5% of OPD staff had completed fire safety training, 100% of OPD staff had completed health and safety training, 97.06% of OPD staff had completed moving and handling training. The department had 99.45% compliance on all mandatory training.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trusts policy.

Assessing and responding to patient risk

- Staff had received mandatory training in patient resuscitation and demonstrated a good knowledge in dealing with medical emergencies.
- In the main OPD, emergency bells were only available in treatment rooms used for taking blood.
- Staff told us that on occasions when the resus team had been called using the dial '2222' telephone system, other staff in the department would be unaware that a medical emergency was happening.
- Staff were told to inform the bleep holder for the department when an emergency call had been made, but we were told that this was mostly not possible as the staff member would be administering emergency treatment whilst the other nurse in the area would be running for resuscitation equipment. This did not leave a member of staff free to alert the rest of the team that a medical emergency was occurring.
- One coordinator told us, "The first time we know of an emergency is when the resus team come running into the department and we don't know where to send them because we don't know what area the emergency is in".
- The fracture clinic area which had been recently renovated had emergency call bells in each treatment room.
- In radiology patients attending from the wards were contacted before the patient was bought down to the department to establish how poorly they were. Any patients with a high early warning score or infection risk

were escorted by ward staff. We were told that the team would involve the site co coordinator if an escort was not available from the ward and they would organise a patient escort.

- CMPE provided specialist radiation advice and support to the radiology department. Radiation protection supervisors had been appointed for each modality and these names were available in the local 'rules' folder.

Nursing staffing

- All of the staff that we spoke with felt that staffing was not an issue in the department and felt that there were enough staff of a suitable skill mix to manage the workload.
- In the main OPD, each area was staffed by a band 3 nursing assistant and two band 2 nursing assistants. A trained nurse worked as a shift coordinator and was used across all areas to support staff with patient care when a trained nurse was required. For example, to administer injections.
- Where areas required a trained nurse to be available for clinics for example Rheumatology clinics, they would be provided.

Medical staffing

- Trust policy states that medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The unit audited compliance with this policy.
- The department used a programme of real time coaching, which involved trained staff observing clinicians in a clinical setting whilst reviewing their interactions with patients. This was not designed to observe clinical competency but comment on detectable behaviours such as such as body language and communication style. Feedback was provided both verbally at the end of the session and in a written report. Clinicians had used this information to form part of their re-validation process.
- The Trust had vacancies in the radiology department. At the time of our inspection they had vacancies for a part time breast radiologist, a full time chest radiologist, one neuro radiologist for stroke expansion and two GU radiologists. The department had plans to support the single handed breast radiologist by training a radiographer to perform breast biopsies and to train assistant practitioners in MRI and plain films. This would release radiographers to train in MRI and plain film reporting. On the week of our inspection a member of staff had started training to perform Dexa scans (Bone Density Scan). Three radiographers were undertaking courses to become competent in reporting radiology examination. (2x Plain X-ray and 1x CT head scanning). In addition, the trust stated that they were working with colleagues from other providers to establish a cross city radiology service, to deal with the vacancy problems.
- The Interventional Radiology service had staffing challenges as although there were enough radiographic staff to cover the service, there were not enough radiologists to provide a robust service. Four radiologists provided non vascular interventions with a fifth radiologist due to start soon. Nursing support for this service was also a challenge. Therefore the neuro vascular work had not been set up formally, to support intra-arterial thrombolysis for stroke patients. We were told that this was on the risk register.

Major incident awareness and training

- The Trust had a major incident plan which was available to staff on the intranet.
- Staff we spoke with were not aware of their role in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Good

The Trust provided a service that was based on national good practice guidance.

Staff were competent and supported to provide a good quality service to patients.

The trust had begun to offer a seven day a week outpatient service in some specialities and was looking to increase this to cope with increasing demand and improve patient experience.

Weekend clinics were well received by patients with low rates of non-attendance.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The OPD assessed each patient who

accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established
- Some specialities such as chest, sexual health and breast surgery had One-Stop clinics. The Trust told us that they were currently looking to expand the number of One-Stop Clinics.
- All rooms that performed radiographic examinations had all the necessary warning notices on the doors and illuminated boxes outside the rooms that lit up when a radiographic exposure was made. All the rooms we saw were compliant with The Ionising Radiations Regulations 1999 (IRR99) requirements. On two rooms that were not in use the doors were locked and the equipment was not switched on. During examinations the examination rooms were locked to prevent unauthorised access.
- We observed posters around the department sign-posting patients who think they may be pregnant to let a member of staff know. All women of child bearing age having examination of the abdominal or pelvic areas are checked for their last menstrual period. We were told that if a patient was pregnant but radiological examination was clinically indicated, then the examination would take place with lead protection being used to protect the foetus. Radiological investigations on women who were pregnant required discussion between senior Radiologist and/or referring clinician to consider the risks v's benefits.

Pain relief

- Patients we spoke with told us that their pain was being managed well by staff in the department.

Patient outcomes

- The OPD ran a continuous patient experience survey which patients were encouraged to complete following their visit to the department. Staff were expected to ensure that 28 surveys were completed in each area of OPD each week.
- Patients completed this on paper as the hand held devices used in other areas of the hospital did not have a robust reception in OPD so could not be used. Friends and Family testing was not being used in OPD but would be started once the system had been adapted for use within the department.
- Results of surveys were shared with staff and patients on display boards within the departments.
- The OPD used these boards to display a 'you said we did' section – these told patients about things that they had said and what the department was doing to improve this for them.
- Comments made by patients during the month were collated and sent to staff. We looked at the January 2014 patient experience feedback comments and saw that staff had addressed some of the concerns raised in the document at the time of our inspection.

Competent staff

- The department held a database which demonstrated that staff had been trained and assessed as competent to use each piece of equipment required to perform their role. We saw that this had been completed for each staff member in the department and was updated annually.
- Temporary staff in the department undertook a staff induction and competency checklist before starting work in the department. We were shown completed documentation. We spoke with one nurse who had worked on the temporary workforce who confirmed that they had completed an induction and competency checklist before working in the OPD.
- All new permanent staff undertook mandatory induction training. This included a corporate and local induction. Staff completed a checklist to ensure that all areas had been completed and this was recorded electronically.
- All permanent nursing staff in the OPD had undertaken venepuncture training and competency assessments.
- The OPD was working alongside the training and development team to create competency education packs for all members of nursing staff. The Assistant Director of Nursing Services (ADNS) was also working with the local university in order to facilitate commencement of student nurse placements in OPD.
- Staff in the department were receiving annual appraisals and monthly 1:1 meetings with their supervisor. This time was protected time and staff told us that they valued this opportunity to discuss their learning and development along with any issues or concerns.
- In radiology staff received induction training which included hospital and departmental policies and the use of equipment. All staff attended the imaging safety group that was run quarterly. Incidents and improvements were discussed. This group fed into the

radiation protection committee where a report was generated and areas discussed included CQC reports, new equipment, incidents and practising safely as an employer.
- The Trust had an E-Learning package on 18 week referral to treatment times for relevant staff. Staff were complimentary about this training and showed a good understanding of the management of 18 week pathways.

Multidisciplinary working

- We saw examples of multidisciplinary working across clinics. For example, In Orthodontic clinics a joint clinic was run every six months with maxilla facial surgeons.
- The Renal Outpatient department provided care for between 480 and 500 patients each week. Clinics were organised according to each patient group speciality for example, transplant clinic, haemodialysis clinic and pre-dialysis clinic. Consultants were supported from a medical perspective by junior doctors and advanced nurse practitioners. Many of the clinics were multi-disciplinary which reduced the amount of clinic visits for patients.
- The OPD offered one stop clinics in some specialities such as breast clinic which also ran a family history clinic where family members could be screened for breast cancer. During the clinic, patients could receive an ultrasound, mammogram, and aspiration dependant on clinical need. The clinic was staffed by a specialist nurse alongside a consultant. Specialist nurses offered a counselling service for patients.
- Staff were able to access dieticians and pharmacy support in clinics where needed.
- Salford Royal's specialist renal clinic for young adults with chronic kidney disease (CKD) won the Managing Long-Term Conditions category in the Health Service Journal Patient Safety + Care Awards 2014. This is a unique service which brings young people with CKD together. The one-stop clinic was designed around feedback from 36 young patients and provides personalised care from medical staff and also from advisers offering counselling, careers and benefits information.

Seven-day services

- Clinics ran across seven days. Weekend clinics were used to assist with capacity where waiting lists demands were greater than clinic capacity.
- MRI and CT scanners run a 7 day service 8am to 8pm. The MRI scanners ran an on call service from 8pm to 8am for clinical situations such as cord compressions, certain neurological scans and interventional procedures.
- Between 8pm and 8am daily the CT scanner was available for emergency work. The radiographer was resident in the hospital to cover this service. General x-rays were available 24 hours a day 7days per week.

Access to information

- All clinics and wards had access to the PAC's which was password protected. The Gateway centre had access to results. GP's were sent paper reports but they could also access radiology reports through the pathology reporting system.
- The PAC's system linked all the patient examinations and reports together which meant that the Radiologist could access all examinations and reports during the reporting process.
- The PAC's system linked in with other systems across Greater Manchester which meant that if the patient had an x-ray examination at another hospital, this examination could be accessed and used in the reporting process at Salford Royal.
- Neurology patient images outside of Greater Manchester could be accessed to support the reporting process. The CRIS system (workflow management system that was integrated with the PAC's system) allowed all images to be accessed for comparison and consistency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although the staff that we spoke with told us that they had received training in The Mental Capacity Act we found that their knowledge was variable with some staff not able to demonstrate a sound knowledge of the principles surrounding this legislation.
- The training database held in the department showed that all staff had completed Mental Capacity Act E-learning training. However six staff had untaken this training in 2008, with others taking it in 2009. The OPD manager was unsure of how frequently staff should access this training.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

We saw very caring and compassionate care delivered by all grades and disciplines of staff working in OPD.

Staff offered assistance without waiting to be asked. Staff worked hard to ensure patients understood what their appointment and treatment involved.

Compassionate care

- One of the strengths of the service in the OPD was the quality of interaction between staff and patients. We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and signposting people in the right direction.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to and maintained eye contact when conversing.
- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff were expected to keep patients informed of waiting times and the reasons for delays. We observed that this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. One patient said, "This is the best hospital staff I have ever seen, it was recommended to me. My views are listened to here".
- Patients also told us that they had been treated with dignity in the department. One patient told us, "I have been treated with compassion and dignity".
- The OPD reception was in the entrance to OPD. The area was busy with patients arriving for appointments. There were signs and barriers to prevent people from crowding around the desks. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that as they checked patient's personal information they ensured that they could not be overheard. This showed that staff had considered ways to ensure that patient's personal information was protected.
- We saw that staff always knocked and waited for permission before entering clinic rooms.
- Patient survey results for October 2014 showed that 95% of patients felt that they had been given enough privacy during their examination and treatment.

Understanding and involvement of patients and those close to them

- We spent time in the department observing interactions between staff and patients.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account. One patient said, "I like the afternoon appointments and staff try to make sure that I get them, I feel that the staff here are very good at their jobs".
- We saw literature being explained to patients in clinic. We saw patients being handed detailed information which was explained to them by nurses who checked their understanding. Nurses also ensured that patients had a contact number to call if they had further questions or concerns when they returned to their homes. There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care. One patient told us, "I would say I have been given the chance to have an input on my treatment plan. I was on one medication that didn't agree with me. The doctor explained all the side effects to me." Another patient said, "The consultant took me through my procedure, and I got the chance to give an input".

Outpatients and diagnostic imaging

- The Service provided chaperones where required for patients. We were told that staff were always available for this.
- Patient survey results for October 2014 showed that 90% of patients felt that their consultations had been explained in a way that they understood, and that their questions had been answered in a way that they could understand.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy.
- We saw an example of staff supporting a frail elderly patient with compassion and dignity. One patient said, "The reception staff are really helpful. When we arrived we were asked if we needed any help. The last time we came here I can honestly say it was a pleasure".
- We also observed a patient who appeared to be in pain. We saw that staff recognised this and went to assist the patient promptly and discreetly. One patient in fracture clinic said, "I feel safe, I feel listened too".

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We found that outpatients and diagnostic imaging services required some improvements in being responsive to patients' needs.

The patient journey through the department and waiting times for patients who required assistance following appointments to return home, meant that some patients were receiving a poor experience in the service.

Referral to treatment times on the 18 week non-admitted pathways were not met across all specialities.

Patients had waited an unacceptable time for results of MRI scans. Although the department had worked hard to rectify the issue they were unable to provide assurance that the issue would not repeat itself. The trust were in the process of reviewing the staffing levels, productivity and capacity to address the issues.

Service planning and delivery to meet the needs of local people

- The OPD was well signposted. On entrance to the main OPD, patients checked in at a newly refurbished entrance desk area. This area was well presented and designed to ensure that private conversations could take place at the desk areas.
- During our inspection we noticed that the queues at the reception desk could become long. We saw patients waiting for between 10 to 15 minutes at times to get to the front of the queue. This was problematical for some patients with issues around their mobility. The department did not have an electronic checking in process for patients to check themselves into clinic.
- We found that patients were walking a fair distance to fracture clinic to be told that they had to return to the main check in desk in order to announce their arrival in clinic. Patients told us that this was frustrating. The sister of the fracture clinic had raised this as a problem and had received funding to improve the layout of the reception area of fracture clinic in order that patients could check in in the department. This work was due to start shortly.
- Each clinical area had patient information boards; these contained a variety of information including staff photos, infection control and hand hygiene audit results, departmental ratings and patient survey results. The department held its own risk register which indicated departmental risks and how these were mitigated or being addressed.
- The renal and orthopaedic and trauma OPD had undergone recent refurbishments which had meant that the areas were well designed and patient seating areas were comfortable. The main OPD was due for refurbishment but there was no date planned for this at the time of our inspection. The main OPD had some areas which were cramped; in particular the chest clinic waiting area was noted to be especially difficult to access for people with mobility aids.
- The OPD had bariatric chairs available in most areas. There was scope for further work on seating, particularly with different height chairs to meet with the requirements of patients who required this.
- The Trust had three 'pay on foot' multi-storey car parks for visitor use. We saw in patient feedback that finding parking spaces could be a problem for patients. Parking

was charged based on the amount of time people were parked for. We saw that where clinics over ran staff could assist patients with partial refunds on their parking costs.

- Patients attending for outpatients and other visitors had access to a coffee shop and restaurant area. Where clinics were delayed staff would provide patients with a pager so that they could visit these areas without missing their appointments.

Access and flow

- In 2012 the organisation opened an ambulance waiting lounge to provide a comfortable seating area for patients who had attended an outpatient appointment and where waiting for another provider to transport or family members to collect them.
- During the inspection we observed an incident in the ambulance waiting lounge where a lone member of staff was being verbally abused simultaneously by a patient in the lounge and another patient's relative on the telephone. The staff member handled the situation well and attempted to calm down the patient and family member, reminding both people about the Trust policy on threatening behaviour.
- Staff members later told us that they experience on average one verbally abusive patient each day in the ambulance lounge with most of the behaviour being directed towards waiting times.
- We were told that if a patient became unwell in the lounge, the nurse would call down to OPD for assistance. Staff told us that this had happened previously. There was no emergency bell in the lounge that staff could use to alert other staff to an incident.
- The ambulance lounge did not have a toilet for patients or hand washing facilities. We were told that the nurse would sometimes escort patients to the public toilet when they needed assistance and that this could leave the lounge unattended by staff. We were told that on occasions ambulance staff had collected patients from the lounge whilst the nurse had been assisting someone in the toilet and that the nurse had not been able to trace where the patient had gone. We observed a patient being incontinent as the nurse was unable to get to the phone to call for assistance from OPD staff.
- Following the inspection we highlighted concerns regarding lone working in the ambulance lounge with the trust and they forwarded assurance of changes made to the service to mitigate future issues during the unannounced period of the inspection. They advised that they would ensure that staff would not be alone in the lounge during peak hours 11am -5pm and that the staffing of the ambulance waiting lounge would be subject to regular audit.
- The nurse and patients in the lounge told us that they were often kept waiting a long time for ambulances. We saw multiple people complaining about this during our visit. It was explained to us that patients had often already had a long wait for a porter to bring them to the lounge and for their medications prior to arriving at the lounge. Staff were not able to log a patient as being ready to be picked up until they were in the lounge and ready to go. This meant that the patient had often had a long wait before the clock had started to tick on their transport wait time home.
- The ADNS acknowledged that ambulance wait times were a frustration for patients and had asked to attend the Ambulance liaison meeting in order to raise concerns. The ADNS had also initiated a patient survey in the ambulance lounge in order to ascertain the extent of the problem and most of the survey responses showed negative comments.
- The ambulance provider who provided transport for patients to clinics and from the ambulance discharge lounge had an agreement with the trust to aim to provide this service to collect a minimum of 80% of patents within 60 minutes and 90% of patients within 90 minutes of the notification that they were ready to be collected. This time was calculated from the point that patients were in the discharge lounge with any prescribed medications and were ready to depart the hospital.
- In the period of April 2014 to December 2014 the Ambulance service had performed below this Key Performance Indicator (KPI) for 6 out of 9 months for the 60 minute KPI and for 8 out of 9 months for the 90 minute KPI. Over this period the service averaged 79.2% on the 60 minute KPI of 80% and 85.5% on the 90 minute KPI of 90%.

Outpatients and diagnostic imaging

- The OPD was trialling opening the ambulance lounge until 8pm at night. We were told that they had extended the opening times because too many patients were not being picked up before the lounge closed.
- We found that the Trust had Issues around the reporting of MRI scans. In October 2014 there were 1,400 MRI scans awaiting reports. We were told by a Trust Director that at one point the number of unreported scans sat at around 2000. We were told that at one point this equated to a 9 – 11 week wait for scans to be reported on**.** At the time of inspection reporting times were down to a maximum of two weeks.
- We were told that the reason for this was that the rise in demand nationally for neurology OPD appointments meant that the Trust had run extra clinics bringing in extra locums to clear waiting lists. As a result there was a large increase in the number of scans being requested creating a temporary capacity gap due to insufficient staffing resources to report on these scans.
- Due to the backlog in reporting scans there was a serious incident around this time where a patient with a brain tumour had a follow up scan to check for recurrence; this scan was not reported in a timely manner. Unfortunately the tumour had reoccurred. The issue was escalated by the clinical team and it was then that the recurrence was reported on the scan. The trust was aware of the incident and fully investigated including appropriate duty of candour to inform the patient.
- As a result of this incident the department had addressed the issue by creating additional activity by the radiologists. The trust re-negotiated existing arrangements with other providers in order that Salford could concentrate on their own work to get the backlog reduced. Staff had also undertaken overtime, and staff rationalised attendance at MDT meetings in order to free up more time. This had reduced the waiting time for reporting to around 2 weeks at the time of our inspection with around 400 scans waiting to be reported on. It was generally agreed by Trust staff that these measures were not sustainable in the long term. A director told us that they could not be confident that this issue will not resurface again unless steps were taken to increase capacity. The trust advised were taking steps to utilise a mobile scanner and they were in the process of approving a fourth MRI scanner.
- The Trust was performing worse than the England average and below the Trust standard of 8% for patients not attending their appointments (DNA). Between April 2013 and April 2014 the Trust averaged 9.75% for new appointments and 10% for follow up appointments. This had got worse with figures from April 2014 to December 2014 showing 10.3% of new appointments and 10% of follow up appointments were not attended by patients. This issue was highlighted in the Trusts OPD improvement objectives for 2014/2015. The Trust aimed to get a DNA rate of 7% across new and follow up appointments for this period.
- The Trust had identified services that did not meet the current DNA standard. They were surveying non attending patients to ascertain the reasons for this. They were planning to change wording in appointment letters to highlight the impact of DNAs, and were planning to do a review of appointment reminders. Currently the service sends appointment letters and text reminders prior to patient's appointments.
- The acute trusts new to follow up ratio was consistently worse than the national average. Between July 2013 and June 2014 the national average was 2.26%. The acute Trust averaged 2.63% for the same period. The Trust had included new to follow-up ratios in the OPD improvement objectives. Services were reviewing their current new to follow-up ratios in order to create service specific ratios. Once this work was complete the Trust would review performance against new ratios.
- We found that the OPD was accurately monitoring patient pathways at the time of our inspection. The central booking service was unable to consistently give patients appointments within the NHS England and Clinical Commissioning Groups (CCG's) regulations 2012 18 week targets across all specialities.
- The last published referral to treatment waiting times showed that between April 2014 and October 2014 the Trust on average saw 93.18% of patients within 18 weeks (The NHS operating standard is 92%). Two specialities were performing below the NHS operating standard for non-admitted referral to treatment time pathways. Trauma and Orthopaedics where 87.9% of patients had completed their pathway within 18 weeks, and Neurology where 86.38% of patients had completed their pathway within 18 weeks.

Outpatients and diagnostic imaging

- The Trust was consistently meeting with the two week wait timescale for patients with urgent conditions such as cancer and heart disease. They were consistently performing above the England average in this area. We were able to see evidence of clear strategies to monitor and maintain robust systems to ensure that the Trust met with these targets.
- The referral to treatment times in the Orthodontic OPD were being achieved consistently. In Oral surgery patients were seen for their first appointment within four weeks and were then treated within the following four weeks, meaning that patients had completed their pathways within eight weeks. In Orthodontics patients were seen for their initial consultation appointment within seven weeks and would then be seen for treatment within five weeks, this meant that patients had completed their pathways within 12 weeks.
- 80% of referrals to the Trust were made through the 'choose and book' system.
- The telephone system in the booking office was automated and staff were able to monitor the number of calls coming in and the length of time they were taking to answer calls. We saw from the statistics that were being constantly monitored by the department's manager.
- Patient waiting times in clinics were monitored by the Trust. From November 2013 to October 2015 57% of clinics started on time and 58% of clinics finished on time. The main reasons for clinic delays were doctors arriving late for clinic, complex patient requirements, not enough doctors for clinic, multiple patients in the same slot and overbooked clinics.
- During our inspection we noted that two clinics in the ENT area were running late, one by 70 minutes and the other by 60 minutes. Clinic delay times were displayed on notice boards and staff were offering patients drink vouchers and pagers so that they could go to the coffee shop and be paged when it was their appointment time. We were told that the reason the clinics were delayed was due to the complexity of some of the appointments that morning and because the clinics had been overbooked. On one of the delayed clinics, eight bookings had been made for four time slots. Staff told us that this was a regular occurrence and that clinics were overbooked, "Multiple times in a week".
- Patient survey results from October to December 2014 showed that 83% of patients had received an apology for late running clinics; this was below the trust target of 85%.
- There was some pressure on the maxillo-facial team in OPD due to a recent public campaign which had increased demand on the service. As a result the team had been running longer clinics to meet with demand and as a result had still managed to meet the two week wait target that they expected to achieve. However, with only one session available each week with the Maxillo facial surgeon consultant this meant that the consultant had to continue working after a very long clinic in OPD. Staff told us that they were hoping to use the money from another post no longer used in the service in order to fund further consultant sessions.
- The radiology department was meeting the 6 week diagnostic target with a 1% tolerance. High pressure areas on targets included MRI and ultrasound. Fluoroscopy and DEXA scanning had a 2-4 week waiting time. Referrals were categorised into urgent, soon and routine with urgent cases taking 2 to 3 weeks (this did not include suspected cancer).'Soon' cases took 3 to 4 weeks, and routine appointments completed within 6 weeks. Demand for radiology appointments had risen in the last year which had placed additional pressure on the department.
- Suspected cancer scans were performed within 7 days. A cancer tracking meeting took place regularly to closely monitor the time cancer patients waited for examinations from the receipt of referral form through to final report being released.
- There was a flagging system in place that would flag those patients with cancer, urgent cases and in-patients. Requests could be escalated if there was a clinical concern. We were told that examinations would be brought forward if escalated by the clinical teams.
- We were told that every week there was a radiology waiting list meeting where all the modality leads attended. During this meeting staff looked at capacity issues and targets. They looked at all the patients on the waiting list focussing on those patients who had waited the longest. This meeting reported into the divisional performance meeting which then reported into the trust wide performance meeting.

- We spoke with medical secretaries from ENT and dermatology departments. They told us that Trust policy stated that letters to General Practitioners (GPs) following clinic appointments would be sent within 5 days. The secretaries that we spoke with told us that they were able to achieve this target consistently. On the day of our inspection they were typing letters from clinics two days before. They told us that their managers traced letter writing targets and would raise it with staff if targets were not being met.

Meeting people's individual needs

- The OPD was able to access telephone translation services for patients. This could be arranged without notice when patients who required the service presented themselves in clinic.
- The OPD had folders for staff which included information for assisting patients with a learning disability. The information included a variety of communication tools, along with information and spare copies of the hospital passport. Hospital passports were completed at home and bought into hospital to give staff information on the best ways to care for the patient's individual needs.
- The ADNS had completed a piece of work examining the number of DNAs from patients who had a learning disability. They had discovered that a proportion of these were due to assisted living accommodation not having staff available to escort patients to clinic. As a result, appointments had been offered in the afternoons when more staff were available to escort patients to clinic. Additionally, the trust had introduced a "meet and greet" service with the aim of supporting patients who may face certain challenges or barriers on arrival to the hospital (such as physical, impairment, cognitive issues or high levels of anxiety). Supported by a team of volunteers, the meet and greet service were able to transfer patients through the use of mobility scooters.
- Staff ensured that patients who may be distressed or confused by the OPD environment were treated appropriately. Patients with a learning disability or diagnosis of dementia were moved to the front of the clinic list. Once in the department they were given a private room where they could sit to wait for their appointment if needed. The OPD staff liaised where needed with ambulance transport staff to ensure that this process ran smoothly.
- The OPD had a link nurse for dementia who ensured that they were informed of new initiatives and best practice and shared this with the rest of the team. Although the OPD did not use the butterfly scheme adopted in the rest of the Trust they did highlight patients with dementia during hourly intentional rounding. The OPD had a resource box for staff including information on dementia and tools such as memory photos to assist people living with dementia.
- Staff told us that where ladies required a female doctor to examine them due to cultural or religious preference this request would always be respected.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy read formats.
- 100% of OPD staff had received training in equality diversity and human rights.

Learning from complaints and concerns

- We discussed complaints with the ADNS and some OPD staff who all demonstrated a good understanding of the trust procedures when dealing with formal complaints.
- The Trust had a 25 day protocol for the completion of formal complaints. Complaints were reviewed at divisional level and any learning from the complaints was fed back to staff in the department. Action plans were instigated following a complaint and staff were given responsibility for ensuring that any actions were completed within the given timeframe.
- We saw evidence from staff meeting minutes that complaints were discussed with staff during these meetings. Staff that we spoke with were able tell us how complaints were discussed and service improvement made as a team.
- We were able to see examples on notice boards around the department where the OPD had listened to patient's feedback on patient surveys and had improved the service as a result. When we talked about complaints staff referred to these examples.
- Most patients we spoke with told us that they would feel comfortable making a complaint and would know how to go about this. One patient said, "I would feel confident in reporting any complaints". Another patient said, "I have made a complaint. I went to reception to complain about delays, I got my parking paid for which I was satisfied with".

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Good

Most staff felt their line managers were approachable, supportive and open to receiving ideas or concerns.

We saw that the Trusts four core values of patient and customer focus, continuous improvement, accountability and respect were incorporated into the way that staff worked across all areas of OPD.

With the exception of call centre staff we were told that staff felt valued and respected in their workplace.

Robust governance and risk management processes meant that staff were able to identify and mitigate risks and identify areas for improvement.

Staff were encouraged to consider and develop ideas that would improve the service.

Vision and strategy for this service

- All of the staff we spoke with were aware of the trusts vision and values. Staff understood what the values meant and we saw staff working to the trust values in every area of OPD.
- OPD vision and developments were a standing agenda item at team meetings. This meant that staff were able to show how the service was learning from patient feedback, incidents, and complaints and were able to demonstrate service improvements that these areas generated.
- Strategies for service improvements were robust and realistic. Progress against targets was monitored to ensure that service improvements were made in a timely manner. Staff were able to confidently discuss their progress on service improvements along with areas that had been identified as still requiring improvement.

Governance, risk management and quality measurement

- The department took part in the Trust wide auditing programme and a governance performance report was delivered each quarter to demonstrate the OPDs performance against targets. The report sent out to department leads for dissemination to staff outlined highlighted areas where performance needed to improve.
- The OPD completed monthly audits of chaperone use and prescription pad use. Matrons had also completed a uniform audit.
- Where issues had been identified audit action plans had been devised and staff that we spoke with were aware of their role in improving audit scores.
- The April 2014 to October 2014 audits showed that the OPD needed to improve in areas such as new appointment to follow up ratios, DNA ratios, and the number of clinics cancelled within six weeks. The results of audits informed the OPD strategy where staff looked at ways to improve processes in order to improve patient experience and outcomes.
- We found throughout our inspection that what staff were identifying to us as risks within their areas of OPD were mostly recognised by the Trust and recorded through risk management and quality measures.
- We found that the recording and management of risks, where identified by the service, was sufficiently robust.

Leadership of service

- The ADNS and Matron were both new in post and demonstrated that they were proactive in making service improvements. The department managers were visible in the department and we saw staff comfortably approaching them for advice or with information. Most staff that we spoke with were complimentary about their leaders.
- The department leads demonstrated how they managed staff using trust policies and procedures for example in sickness management. The sickness rates in the main OPD had been consistently higher than the trust target over the past year with the average at 13.2% between April 2014 and November 2014. The ADNS demonstrated how this was being managed using Trust sickness policies and Occupational Health.
- The department leads had recently implemented a new system for staff to request annual leave electronically.
- The department leads had attended the clinical leadership programme. They were very positive about

the programme and described it as, “Inspirational, and motivational”. One lead had been allocated the chief executive as their executive sponsor. They said that they had initially found this intimidating and had thought that they would not get much time with the CEO as he was so busy. They described the assistance they were given by the CEO as, “Amazing”. They said that he spent lots of time with them, coaching and supporting them, including hospital walk-abouts, and presentations. Another lead said that their sponsor had challenged them and made the experience “hard work but rewarding”.

Culture within the service

- Nursing and radiology staff that we spoke with across all areas of OPD told us that they felt proud to work for the trust and felt respected and valued by their managers.
- The department ran a ‘staff member of the month’ initiative which was a staff suggestion.Colleagues nominated each other for behaviour that demonstrated the department’s values with awards going to staff who had ‘gone the extra mile to ensure that patients had a positive patient experience during their visit to the OPD’.
- One technician working in the ENT department told us that they felt “So supported I have to pinch myself, this is such a good Trust to work for”.
- However, call centre staff told us that as a staff group they felt undervalued. They told us that they were under pressure to meet targets and that they were receiving constant emails from their managers asking why tasks hadn’t been completed. One staff member said, “At first I found it intimidating, but I have just got used to it now”.
- One member of call centre staff told us that they would not feel able to whistle blow in the Trust. They said that this was because they “didn’t have confidence in the whistle blowing mechanisms”.They said that this was because where a staff member had whistle- blown to the human resources department, their manager had been made aware of it.
- We found staff were open and honest with us throughout our inspection about both the good parts of their service and the areas that required improvement.
- Staff told us that they were encouraged to be open and honest and felt that they worked in a culture of no blame.

Public and staff engagement

- We saw minutes of staff meetings were the matron had shared patient stories and compliment letters received about staff in the department. A standing agenda item for this meeting was patient stories, compliments, complaints and incidents.
- All of the staff we spoke with placed a high importance on patient experience. They were able to describe to us how they had made improvements to patient journeys through the department and how they received feedback when patient’s experiences did not meet with the vision and values of their department.
- Where a member of staff had been a patient in the trust they were invited by the patient experience team to share their experiences of care.
- Patient comments from surveys were collated and disseminated to staff in the form of a booklet. Staff were able to read these comments and we were shown areas that had been improved as a direct result of this feedback.

Innovation, improvement and sustainability

- The ADNS actively encouraged staff innovation and had devised a tree poster which was displayed in staff areas where staff could make suggestions of innovative ideas.We saw that this had been utilised by staff.
- Housekeeping staff in the OPD had rearranged a store cupboard in order to make to OPD more productive. This had also made a cost saving to the department of £300. This was acknowledged during a staff meeting and staff members were congratulated on their innovation and hard work.
- Where one member of staff had devised a way to allocate staff within their OPD area, they were encouraged to share this good practice with the rest of the team. This was made an action point following discussion at a staff meeting.
- Staff we spoke with told us that they were encouraged to consider and feedback innovative ideas. They said that they would feel confident doing this and would feel that their ideas were listened to.

Outstanding practice and areas for improvement

Outstanding practice

- Nursing assessment and accreditation systems (NAAS) provided a high level of transparency to the trust's board and to patients in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider and scrutinise.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. The accolade of SCAPE was seen as significant success by clinical leaders and ward based staff.
- There was clear evidence that the development of the 'emergency village' with its integrated care pathway approach, including medical in-reach, continued to deliver improved outcomes for people.
- Quality improvement initiatives had successfully led to a reduction in the number of hospital acquired pressure ulcers.
- Staff were encouraged to undertake research, for example, we reviewed a paper published in respect of improving patient care in a national intestinal failure unit.
- The surgical division celebrated its positive arrangement for moving elective orthopaedic work off site, and anticipated that this would improve patient throughput, standardise use of prosthetics and develop a centre of excellence.
- The surgical division indicated that it had established a link with Central Manchester NHS Foundation Trust, which it anticipated could lead to future partnership working in the developed Manchester Orthopaedic Centre. This was expected to lead to increased pooled volumes of specialist activity with standardised practice leading to improved patient outcomes.
- The surgical division's annual plan described the development of a service model for emergency and complex surgery with two other NHS providers.
- We saw in the theatre staff newsletter for December 2014, an introduction to the forthcoming 'Theatre Improvement Programme'. We were told this was due to start at the end of January 2015, with the aim of ensuring that theatres could provide safe and reliable care, provide value and efficiency and deliver a high team performance with high team morale and wellbeing. This work was being co-ordinated and delivered through a Quality Improvement methodology, led by a steering group headed by the Director of Organisational Development and Corporate Affairs. We saw from information provided to us that the programme was based around the Productive Operating Theatre model, developed by the NHS Institute for Innovation and Improvement.
- The senior managers within the surgical directorate recognised the areas for further focus, which included interventional radiology, middle grade recruitment to medical staff, the delivery of complex emergency care and making improvements to the discharge process, by reviewing and enhancing the patient pathway.
- There was an incentive for staff who wished to be involved in helping the trust to make financial savings to the service. If an idea was adopted, the staff member received 10% of the overall savings as a reward for their innovation.
- Junior staff were rotated to other areas across the critical and high dependency care units to facilitate personal progression and encourage staff retention.
- Bleeps were provided to relatives so that staff could contact them quickly if they were away from the CCU.
- The diabetes outpatient service demonstrated good practice where children in transition from young people to adulthood were seen in a clinic attended

Outstanding practice and areas for improvement

by an adult physician and adult specialist nurses, giving dietetic and psychological support. This ensured a continuous and consistent pathway of care through to adulthood.

- We were told the trust was actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. The trust had piloted the use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB), which were used to support patients that are assessed as acutely unwell deteriorating, with limited reversibility and where recovery is uncertain however, it was decided not to continue to implement the ACB after the pilot.
- Other improvement areas include Advance Care Planning (ACP), EPaCCS, rapid discharge pathway, meeting the priorities for care of the dying person and effective care after death, including bereavement and mortuary service.
- Innovative work undertaken included the access to seven-day Specialist Palliative Care for SRFT since 2009 (only 21% of trusts deliver this nationally). The trust has participated in all four rounds of the NCDAH and the trust was described as above the national average for nine out of 10 Clinical KPIs. The bereavement care delivered across the trust and the trust's awareness around cultural needs of the population were well met by the HSPC, bereavement and the chaplaincy teams.
- The system of daily safety huddles, and intra-team situation reports ensured that important information was passed between teams and shifts.
- The team-based audit programme and the monitoring of results and actions.

Areas for improvement

Action the hospital MUST take to improve

- The trust must take action to ensure that WHO safety checks (or equivalent) are conducted on all patients going through operating theatres, and it must take action to ensure that monitoring of WHO safety checks are carried out.
- The trust must ensure that the environment is appropriately maintained and fit for purpose; the main outpatient department experienced a regular leaking roof in several areas, and sewage leaks through the ceiling.

Action the hospital SHOULD take to improve

- The trust should ensure that safety checks on technical equipment used in the delivery of treatment and care to patients are carried out routinely. This is something that is required as part of Regulation 16, safety, availability and suitability of equipment. It was considered that the omissions related to the checking of anaesthetic machines by theatre staff were not proportionate to support a judgement of a breach of the regulation.
- The trust should ensure that the knowledge and application of the Mental Capacity Act and the Deprivation of Liberty Safeguards is consistently applied across all services.
- The trust should consider prioritising the improvement of the discharge process for patients from beyond the local area to the wider geographical area.
- Whilst we acknowledge that the trust has embarked on a programme of quality improvement within theatres to improve the culture and morale of the department, the trust should ensure that this initiative is both effective and sustainable so that changes are fully embedded for the future.
- The trust should consider ways of reducing the rate of surgical procedure cancellations.

Outstanding practice and areas for improvement

- The trust should consider a unified strategy for the delivery of children's services, both medical and surgical. Governance systems, risk management and performance measurement processes should be standardised to ensure children receive quality, evidence based care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used the service were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This was because the planning and delivery of treatment and care did not ensure the welfare and safety of patients in the operating theatres. Further, such risks did not take into account appropriate published research evidence and guidance as to good practice in relation to treatment and care. Regulation 9(1)(b)(ii) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who used the service and staff were not protected against the risks associated with unsafe or unsuitable premises. 15.(1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of (a) suitable design and layout; (c) adequate maintenance and, where applicable, the proper— (i) operation of the premises

This section is primarily information for the provider

Compliance actions

Regulation 15 (1)(a)(c)(i) Health and Social Car Act 2008 (Regulated Activities) Regulations 2010