

Tameside and Glossop Integrated Care NHS Foundation Trust

Quality Report

Tameside and Glossop Integrated Care NHS
Foundation Trust,
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This report describes our judgement of the quality of care at this trust. 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 trust

Good 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

Tameside and Glossop Integrated Care NHS Foundation Trust is a major provider of hospital services in Tameside and Glossop, providing care to a population of approximately 250,000. Care was provided from a single acute hospital site situated in Ashton-under-Lyne.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures because there were concerns about the care of emergency patients and those whose condition might deteriorate. There were also concerns about staffing levels (particularly of senior medical staff at night and weekends), patients' experiences of care and, more generally, that the trust board was too reliant on reassurance rather than explicit assurance about levels of care and safety.

We carried out a comprehensive inspection of the trust in 2014 and followed up our inspection findings in a focused inspection April 2015. As part of this inspection a number of improvements were recognised particularly in critical care.

However, in April 2015 we remained concerned in respect of the safety, effectiveness and responsiveness of some services particularly in medical care (including frail elderly).

This inspection was a fully comprehensive inspection to ensure improvements had been continued and sustained.

We inspected Tameside and Glossop Integrated Care NHS Foundation Trust on 8-11 August 2016.

We inspected

- Urgent and Emergency Care Services
- Medical Care (including Frail Elderly)
- Surgical Services
- Critical Care Services
- Maternity and Gynaecology
- Children and Young Peoples Services
- End of Life Care
- Outpatient and Diagnostic Imaging Services.

Our key findings were as follows:

We were pleased to note that the trust had continued to make improvements in a number of key areas particularly in urgent and emergency care.

Good progress had been made that resulted in the 'requires improvement' rating for urgent and emergency care services being increased to 'good'.

Vision and Leadership of the trust

- The trust was led and managed by a stable, visible and accessible executive team. The senior team led the trust with a good focus on service quality and positive patient experience. Staff confirmed that it was commonplace to see the senior team and Chief Executive in the wards and departments.
- The trust's aim was 'to deliver, with our partners, safe, effective and personal care, which you can trust'. This was underpinned by a set of values and behaviours that were based on safety, care, respect, communication and learning.
- The trust's aims, values and behaviours were well understood and adopted by all staff groups.

Culture within the trust

- There was, in the main a very positive culture throughout the trust.
- Staff of all grades were committed to the continuous improvement regarding the quality of care and treatment delivered to patients.
- Staff felt comfortable and confident in respect of raising matters of concern. In addition staff felt that they could share ideas for improvement and innovation with managerial support.
- There was a range of reward and recognition schemes that were valued by staff. Staff were supported to be proud of their service and celebrate achievements.

Governance and risk management

- The trust's governance arrangements were centred on the divisional structure of services. Each division was managed by a triumvirate of manager, nurse and doctor. The triumvirates reported to the board through a committee structure.

Summary of findings

- Mechanisms were in place to ensure that committees were managed and reported appropriately so that performance was challenged and understood. There was challenge and scrutiny by non-executive directors in respect of quality and risk.
- The Board Assurance Framework (BAF) was suitably aligned to strategic objectives and was linked appropriately to divisional risk registers.
- There were divisional governance meetings where performance, risks and learning was discussed and shared. Staff had access to management information to support good performance which included trends and correlation of data to promote identification of poor performance and support timely action planning.

Mortality rates

- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by robust and well understood review and escalation procedures. All deaths were reviewed. Key learning points were cascaded to staff appropriately.
- Lessons learned were disseminated through the divisional governance structure to enable appropriate actions to be embedded and learning from mortality reviews to be shared by divisional teams. The review of every death provided an assurance of quality care delivery and provided valuable information and learning regarding avoidable deaths.
- The mortality review proforma incorporated recommendations and guidance from NHS England, PRISM2 study and the Mazars report (2015).
- Monitoring arrangements were in place at board level to ensure that opportunities for learning and improvement were implemented.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators, which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The December 2014 to December 2015 SHMI of 115 was above the 'expected' level (100). The trust's HSMR for the latest 12 month period (to February 2016) is 92.6. The trust investigated the reasons for the divergence in these indicators performance the action put in place were
- A mortality review process of the care provided for all inpatient deaths.

- A Trust Mortality Steering Group, where improvement is tracked through monthly performance monitoring and national benchmarking tools, are used to flag areas of concern.

Safeguarding

- The trust had safeguarding policies and procedures in place which were readily available on the trust's intranet site. Policies were supported by staff training. The trust had improved its performance with regards to adult safeguarding staff training, 98% of staff having received training in 2015-16 raising awareness.
- The majority of staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- Overall, safeguarding training was above the trust's target of 95% and across the trust averaged 98% for safeguarding adults and 99% for safeguarding children. However, there were departments within the trust where safeguarding children's training compliance levels were below the trust's target. These areas included medical and nurse staffing within A&E, the medical division and women's services.
- The trust had an internal safeguarding team who could provide guidance and support to staff in all areas. This team were easily accessible by telephone and email. During out of hours periods staff had access to senior nursing staff within the hospital management team to seek advice and guidance on safeguarding issues.
- The team worked with staff, patients and families to develop plans of care in order to fully meet the patient's individual needs. This included support for people living with dementia, a learning disability, and autism spectrum conditions, patients with physical disabilities and patients with mental illness.

Nurse Staffing

- Nurse staffing levels, although improved remained a challenge in a number of areas particularly in the medical directorate. Staffing levels were maintained by staff regularly working overtime and with the use of bank or agency staff.
- Where possible, regular agency and bank staff were used which meant they were familiar with policies and procedures. Any new agency staff received an induction prior to working in the hospital.

Summary of findings

- We reviewed a report produced on the 27 April 2016. The report indicated that a number of wards in the medical directorate were below 80% staff fill rates for qualified day staff. The report highlighted issues in ward 41, 44 and 46 where qualified nurse fill rates were between 79% to 74%. This was escalated to board level and in the the safer staffing report of July 2016 it was noted that getting the correct numbers of nurses, midwives and healthcare assistants in place was essential for the delivery of safe and effective patient care and the chief nurse was providing scrutiny, leadership and oversight of this essential area of quality and safety.
- The trust was actively recruiting nationally to address the nursing vacancy rates currently at 89% for day staff and 98% for night staff (June 2016) .
- The trust was working with other agencies to fill rota gaps to maximise nurse staffing capacity. Never the less, there were times when wards were not fully staffed.

Midwifery Staffing

- A review of midwifery staffing numbers had been undertaken in January 2016 using birth-rate plus criteria and calculation tool, in line with the NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE, 2015). This identified a growing number of births with impact on the required number of midwives which was to be monitored via the maternity dashboard.
- We saw when midwife numbers were below those planned for a shift additional staff were sourced and put in place. The labour ward coordinator was responsible for monitoring any shortage of staff and capacity issues.
- Recruitment of midwives was not difficult for the trust. 13 midwives which represented 9.7 whole time equivalent midwives had been recruited to start work between August and October 2016. This would meet the vacancy rate of 9.8 full time posts.
- The midwife to birth ratio had been 1:30 in June but had improved to 1:28 with new midwives starting employment.
- We were told one to one care in labour was achieved.
- Two midwives were on call to assist at any home births out of hours.

- A new manager for the community midwives had been appointed in June 2016. The current systems of working were under review and a new model was being considered.
- Community midwives and the community midwife manager were unable to tell us how many patients they had on their caseload. Therefore there was no management of the equity or suitability of the size of community caseload. During the inspection one midwife had accepted seven visits which they could not complete. Managers were aware of this and a scoping exercise to address it had begun.
- There was a midwife from the enhanced team based in the hospital Monday to Friday 9am to 5pm and one on call in the community. Out of these hours safeguarding support was provided by the on call supervisor or the children's safeguarding team.

Medical Staffing

- The proportion of middle career doctors and junior doctors within the trust was greater than the England average. The proportion of consultants was below the England average (37% compared with the England average of 42%). The proportion of registrars was also below the England average (27% compared with the England average of 36%).
- These figures were an improvement from last year and the urgent and emergency care department had slightly above the England average number of consultants. The trust continued to work with other trusts to look at innovative ways to recruit and retain staff, including overseas recruitment and talent management. At the time of our inspection in surgical services there were appropriate numbers of medical staff to meet the needs of patients.

Cleanliness and infection control

- Clinical areas at the point of care were visibly clean, the trust had infection prevention, and control policies in place that were accessible to staff and staff were knowledgeable about their role in controlling and preventing infection.
- Staff followed good practice guidance in relation to the control and prevention of infection in accordance with established trust policies and procedures.

Competent Staff

Summary of findings

- Newly appointed staff had an induction for up to four weeks and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Practice educators that oversaw training processes and carried out competency assessments based on national competency guidelines.
- Staff told us they routinely received supervision and annual appraisals. Records up to June 2016 showed the appraisal rate was 95.6%. This showed the majority of staff had completed their annual appraisals and the hospital's internal target of 90% appraisal completion was achieved across all
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

We saw several areas of outstanding practice including:

- The main Hartshead building was designed with input from a disabled patient user group. Access to the building was good with clear signposting. There was a team of volunteers that provided mobility scooters by request and supervised their use throughout the hospital so patients with mobility difficulties could move through the site easily.
- The radiology department offered a "Virtopsy Service". This virtual post-mortem service was used when a CT scan could determine the cause of death. This speeded up the process of determining cause of death and respected the religious and cultural needs of some of the local population. Scans were carried out at night and reporters were experts in reporting on virtual post-mortems. Deceased persons were transported to the unit via a private corridor. The trust was one of the first in the North West to offer this service.

However, there were also areas of practice where the trust must make improvements.

Importantly, the trust MUST:

Urgent care

- Ensure that patients can access emergency care in a timely way.
- Ensure all staff receive mandatory training at the required level and within the appropriate time frame.
- Ensure that fridges used to store medications are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.

Medical Services Including Older People

- Ensure there are appropriate numbers of nursing staff deployed to meet the needs of patients

Children and Young People

- Ensure all equipment used to provide care or treatment to a service user is properly maintained.
- Ensure that there is one nurse on duty on the children's ward trained and up to date in Advanced Paediatric Life Support on each shift.

In addition the trust SHOULD:

Urgent and emergency care

Summary of findings

- Ensure that staff receive their annual appraisal.

Medical services including Older people

- Ensure children's safeguarding training across all professions within the medical directorate is up to date.
- Look to reduce the number of medical patients being cared for on surgical wards.
- Continue to monitor staffing arrangements on wards.

Surgical Services

- Take appropriate actions to improve mandatory training compliance rates.
- Take appropriate actions to reduce the number of cancelled elective operations.

Maternity and gynaecology

- Ensure the improvements in the infection prevention and control measures and the environment on ward 27 should continue.
- Emergency medicines should be safely stored in the obstetric theatre in line with trust's policy for the safe use of emergency medicines.
- Records should be securely stored in the ward areas.
- Appropriate actions should be taken to improve the mandatory training compliance rates for infection control and children's safeguarding.
- Ensure that a deteriorating patient's care was managed in line with the trust's policy.
- Continue to make improvements in the completion of the safer surgery checklists.
- Develop a system to ensure patients received required home visits by the community midwives.

Children and Young People

- Ensure recording of fridge checks include the maximum and minimum temperatures in accordance with national guidance.
- Ensure dates of cleaning and safety checks are legible on equipment.
- Review documentation for infants when intervention is reduced to high dependency or special care.
- Ensure the security and confidentiality of medical records in the paediatric outpatients department.
- Ensure PEWS documentation is completed and audited to improve compliance.
- Ensure the neonatal unit consistently collect patient feedback using the NHS Friends and Family Test.

- Ensure inpatient discharge summaries and outpatient clinic letters are sent in a timely way.
- Ensure regular staff meetings take place on the neonatal unit.

End of life care

- Consider how it can increase uptake of the use of the individual care plan for end of life care patients.
- Consider how it can encourage improvement in the accuracy and completeness of DNACPR forms, including the undertaking and recording of mental capacity act assessments, the recording of best interests decisions, and discussions with patients and their relatives.
- Consider reviewing information held within the palliative rapid discharge link nurse files held in wards and units across the trust to ensure the information held is accurate, up to date, and in line with prescribing and dosage guidelines for anticipatory medicines.
- Consider what actions it could take to further increase the proportion of end of life care patients dying in their preferred place of care.
- Consider what actions it can take, within its control and where requested, to increase the percentage of end of life care patients discharged within the timescales of the rapid and fast discharge process.

Outpatients and Diagnostics

- Continue the active recruitment of radiologists to meet actual WTE requirements and maintain safe staffing levels.
- Resolve the issue of allied health professionals being unable to accurately record mandatory training levels.
- Carry out an infection control risk review of positioning aids foam pads in radiology, to ensure that the risk of infection is minimised.
- Ensure that all entries on patient notes are signed and dated.
- Continue to increase the numbers of staff who have undertaken children's safeguarding training to meet trust targets.
- Review version controls on Local Rules for Radiation Protection and ensure that all staff have signed them to indicate that they have read and understood them.
- Continue to seek a solution to the lack of an electronic system that interfaces with local GP surgeries.

Summary of findings

- Continue to seek viable solutions to reduce “Did Not Attend” (DNA) rates.
- Continue to seek solutions to improve “Referral to Treatment” (RTT) times so that all clinical pathways met national standards.
- Review the consultation room in clinic nine where the door opens outwards to improve privacy and dignity for patients.
- Review the children’s play area in outpatients' clinics six to nine to see whether this could be better located or children observed and kept safer.
- Improve patient knowledge of how to access PALS should they need to do so.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside General Hospital is part of Tameside and Glossop Integrated Care NHS Foundation Trust. Tameside General Hospital is situated in Ashton-under-Lyne. The hospital services a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire. In total, the trust has 538 beds and employs approximately 2,245 members of staff. In 2015/2016 the trust had 52,475 admissions (23,908 inpatient and 28,567 day cases), 310,068 outpatient attendances and 84,770 A&E attendances. During this inspection, the team inspected the following core services:

- Urgent and Emergency Services
- Medical Care Services (including older people's care) and the Stamford Unit
- Surgery
- Critical Care
- Maternity and Gynaecology
- Children and Young People
- End of Life Care
- Outpatients and Diagnostic Services

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh OBE FRCP, is a consultant in medicine for the elderly.

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, eight CQC inspectors, two CQC assistant inspectors, a CQC analyst, a CQC inspection planner and a variety of specialists including: an emergency nurse practitioner specialising in

urgent care, a consultant physician, a matron in the medical investigations and respiratory care, a consultant in general & vascular surgery, a critical care doctor, a risk midwife, a consultant paediatrician, a clinical nurse specialist in palliative care, a consultant in palliative medicine, an imaging general manager and lead radiographer, a senior quality and risk manager and an expert by experience. (Lay members who have experience of care and are able to represent the patients voice).

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Tameside General Hospital and asked other organisations to share what they knew about the

hospital. These included the clinical commissioning groups, NHS Improvement, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

The announced inspection of Tameside General Hospital took place on 8, 9, 10 and 11 August 2016. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

Summary of findings

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

We undertook an unannounced inspection between 4pm and 8.30pm on 18 August 2016.

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

Facts and data about this trust


Tameside and Glossop NHS Foundation Trust was established on 1 February 2008. Previously, the Trust had operated as Tameside and Glossop Acute Services NHS Trust since 1994.

- The trust operates from the Tameside General Hospital site, which is situated in Ashton-under-Lyne. Tameside is ranked 42nd most deprived LA (out of 326) in the country
- The hospital services a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire.
- Around 9% of the population in Tameside is BME, compared to 14.5% of the population in England.

- The health of the population in Tameside is generally significantly worse than that of the general population in England. Life expectancy for both males and females is significantly worse than the England average.
- There are inpatient 538 beds: 316 General and acute, 40 Maternity and nine critical care.
- The trust employs approximately 3,399 staff: 256 medical, 1,129 nursing and 2,014 other.
- In 2015/2016 the trust had 52,475 admissions (23,908 inpatient and 28,567 day cases), 310,068 outpatient attendances and 84,770 A&E attendances.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated the trust as 'requires improvement' for being safe. This was because:</p> <ul style="list-style-type: none">• Nurse staffing levels, although improved remained a challenge in a number of areas particularly in the medical directorate.• The trust had been affected by a national shortage of radiologists and had four full times in post against an establishment of 9.1 WTE. Safe staffing levels were maintained and the variance had been reduced, by the use of locum staff.• Some of the environment and equipment on ward 27 did not meet infection prevention and control standards. Action had been taken at the unannounced inspection with further work planned to address the identified shortfalls. <p>However,</p> <ul style="list-style-type: none">• The trust had robust systems and processes in place for protecting patients from avoidable harm. Systems for protecting patients from avoidable harm were robust. Reporting of incidents was encouraged throughout the trust the rationale being to demonstrate an open culture and promote learning.• All staff understood the duty of candour principles and processes.• The quality and governance team had developed a very robust system that ensured all duty of candour incidents were picked up and proactively managed. <p>Incidents</p> <ul style="list-style-type: none">• The trust had systems and processes in place for reporting incidents. Staff were able to demonstrate, the reporting system via the trust's intranet and describe the types of incidents that would be reported.• The trust increased the number of incidents reported to the NRLS by 37% in 2015 making the trust the 15th highest reporter in the country.• The trust has been awarded an outstanding status in the DOH 'new learning from mistakes table'. The trust came 8th place nationally out of 230 trusts. This level of performance is indicative of a positive reporting culture.• Staff were encouraged to be open and report all incidents so learning can be implemented.	<p>Requires improvement</p> 

Summary of findings

- We saw evidence that staff at all levels were involved in the investigation process for all incidents (including serious incidents).
- Staff told us they felt positively about being involved in the root cause analysis investigation process and they felt the process was constructive and presented as a opportunity for learning and improvement rather than a punitive process.
- Managers shared lessons learned from incidents with frontline staff through individual feedback, communications on notice boards and staff meetings. Active practice development teams organised teaching sessions on a variety of subjects including issues highlighted through incident investigation and reviews. The team also worked on a one to one basis with staff to learn from incidents where appropriate.
- The trust set a number of goals regarding reducing a number of key patient safety incidents including post operative haemorrhage, post operative sepsis, post operative deep vein thrombosis all these had been achieved.
- The trust was working with commissioner and other providers to develop a system for anticipating and predicting future harm.

Duty of Candour

- Every working day the quality and governance team is provided with a list of reported incidents occurring trust wide in the previous 24 hours.
- All incidents were then reviewed and systematically followed up to ensure appropriate implementation of duty of candour had occurred.
- A look back exercise and position report was produced by the trust in June 2016 to ensure the process was carried out in line with the trusts regulatory duties and encourage best practise.
- The report showed that nine of the 15 most serious incidents reported, independent external opinion had been sought the remaining six had been subject to an internal review.
- The principles of duty of candour were understood by medical and nursing staff.
- The trust demonstrated an open and honest culture with patients and relatives and had developed information leaflets explaining the duty of candour and investigation process.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This is a basic set of observations such as respiratory rate, temperature, blood pressure and pain score and is used to alert staff to any changes in a patient's condition.

Summary of findings

- Early warning indicators were regularly checked and assessed. When patient scores indicated that medical reviews were required, staff had escalated their concerns and secured prompt and timely medical intervention.
- Upon admission staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on suitable care pathways, and care plans were put in place to ensure they received appropriate care.
- Risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).

Safety thermometer

- The NHS safety thermometer is a national initiative and is a local improvement tool used to measure, monitor and analyse patient harm, and harm free care.
- The trust safety thermometer data for March 2016 confirmed that 98% harm free care was achieved.

Mortality and Morbidity

- Following concerns that the trust was either a risk or an elevated risk for the some mortality outliers including gastroenterological and hepatological conditions and procedures, infectious diseases, nephrological conditions, vascular conditions and procedures, a process to review every death had been started by the trust. This provided an assurance of safe and quality care delivery and was recognised by the clinicians as not just a box ticking exercise.
- Mortality review outcomes were discussed at a mortality steering group chaired by the medical director, which fed into the service quality and operational governance group and the quality and governance group for oversight and scrutiny. Lessons learned were disseminated through the divisional governance structure to enable appropriate actions to be embedded and learning from mortality reviews to be shared by divisional teams.

Safeguarding

- The trust had safeguarding policies and procedures in place which were readily available on the trust's intranet site. Policies were supported by staff training. The trust had improved its performance with regards to adult and children's safeguarding training. Staff training stood at 98% for safeguarding adults and 99% for safeguarding children.
- The majority of staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.

Summary of findings

- The trust had an internal safeguarding team who could provide guidance and support to staff in all areas. This team were easily accessible by telephone and email. During out of hours periods staff had access to senior nursing staff within the hospital management team to seek advice and guidance on safeguarding issues.
- The team worked staff, patients and families to develop plans of care in order to fully meet the patients' individual needs. This included support for people living with dementia, a learning disability, and autism spectrum conditions, patients with physical disabilities and patients with mental illness.

Cleanliness and infection control

- The majority of clinical areas at the point of care were visibly clean. However some of the environment and equipment on ward 27 did not meet infection prevention and control standards. Action had been taken at the unannounced inspection with further work planned.
- The trust had infection prevention, and control policies in place that were accessible to staff and staff were knowledgeable about their role in controlling and preventing infection.
- Staff followed good practice guidance in relation to the control and prevention of infection in accordance with established trust policies and procedures.
- As part of the inspection we observed staff washing their hands appropriately, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care. We saw staff adhering to the 'bare below the elbows' policy when in the clinical areas.
- We saw that monthly hand hygiene audits were carried out by the infection prevention team compliance rates were between 92% and 100% in May 2016. However, some of the environment and equipment on ward 27 did not meet infection prevention and control standards. Action had been taken at the unannounced inspection with further work planned.

Medication

- The procedure used by anaesthetists to prepare emergency medicines in the obstetric theatre did not meet the safe management of medicines guidance.
- Emergency equipment was located in a number of trolleys and boxes in the high dependency area of the children's unit and emergency intravenous fluids were secured in a padlocked cabinet alongside. This meant that in an emergency access to equipment and the fluids may be delayed.

Summary of findings

- Medicines fridges were secured and the fridge temperatures recorded daily, however maximum and minimum temperatures were not recorded in accordance with national guidance.

Nurse Staffing

- Nurse staffing levels, although improved remained a challenge in a number of areas particularly in the medical directorate. Staffing levels were maintained by staff regularly working overtime and with the use of bank or agency staff.
- Where possible, regular agency and bank staff were used which meant they were familiar with policies and procedures. Any new agency staff received an induction prior to working in the hospital.
- We reviewed a report produced on the 27 April 2016. The report indicated that a number of wards in the medical directorate were below 80% staff fill rates for qualified day staff. The report highlighted issues in ward 41, 44 and 46 where qualified nurse fill rates were between 79% to 74%.
- The trust was actively recruiting both nationally and internationally to address the nursing vacancy rates currently at 89.3% for day staffing and 98.1% for night staffing, these vacancy rates were similar to other similar trusts.
- The trust was also working with another trust to help fill rota gaps across both trusts by working together to maximise nurse staffing capacity.
- Never the less, there were times when wards were not fully staffed. Work is underway to develop a Nursing and Midwifery Staffing Dashboard including all the information about staffing figures in one dashboard enabling the board to look at information that includes nursing, midwifery and paediatrics and neonates staffing information. It was recognised in the safer staffing paper discussed at the trust board in July 2016 that getting the correct numbers of nurses, midwives and healthcare assistants in place was essential for the delivery of safe and effective patient care. The paper shows that the chief nurse is providing scrutiny, leadership and oversight of this essential area of quality and safety.

Midwifery Staffing

- A review of midwifery staffing numbers had been undertaken in January 2016 using birth-rate plus criteria and calculation tool, in line with the NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE, 2015). This identified a growing number of births with impact on the required number of midwives which was to be monitored via the maternity dashboard.

Summary of findings

- We saw when midwife numbers were below those planned for a shift additional staff were sourced and put in place. The labour ward coordinator was responsible for monitoring any shortage of staff and capacity issues.
- Recruitment of midwives was not difficult for the trust. 13 midwives which represented 9.7 whole time equivalent midwives had been recruited to start work between August and October 2016. This would meet the vacancy rate of 9.8 full time posts.
- The midwife to birth ratio had been 1:30 in June but had improved to 1:28 with new midwives starting employment.
- We were told one to one care in labour was achieved.
- Two midwives were on call to assist at any home births out of hours.
- A new manager for the community midwives had been appointed in June 2016. The current systems of working were under review and a new model was being considered.
- Community midwives and the community midwife manager were unable to tell us how many patients they had on their caseload. Therefore there was no management of the equity or suitability of the size of community caseload. During the inspection one midwife had accepted seven visits which they could not complete. Managers were aware of this and a scoping exercise to address it had begun.
- There was a midwife from the enhanced team based in the hospital Monday to Friday 9am to 5pm and one on call in the community. Out of these hours safeguarding support was provided by the on call supervisor or the children's safeguarding team.

Medical Staffing

- The proportion of middle career doctors and junior doctors within the trust was greater than the England average. The proportion of consultants was below the England average (37% compared with the England average of 42%). The proportion of registrars was also below the England average (27% compared with the England average of 36%).
- These figures were an improvement from last year and the urgent and emergency care department had slightly above the England average number of consultants.
- The trust continued to work with other trusts to look at innovative ways to recruit and retain staff, including overseas recruitment and talent management.
- At the time of our inspection in surgical services there were appropriate numbers of medical staff to meet the needs of patients.

Summary of findings

Mandatory training

- Mandatory training compliance was reviewed regularly by the practice development leads and the managerial staff within the departments and divisions.
- Uptake levels for most mandatory training subjects were variable between subjects with some areas of high uptake, which met the trusts target (95%), (adult safeguarding 98% and equality and diversity training 98%) and some areas of low uptake which did not meet the trusts target (infection prevention 87%, health and safety 93% and fire 94%).
- There were nine subjects which staff were required to undertake mandatory training in, some subjects required that they were undertaken on a yearly basis and others on a two yearly basis. The trust was meeting the target for six of the nine subjects, where the division was not meeting the trust target the practice development lead had actions in places to address these issues. Staff told us they were encouraged to attend mandatory training and the practice development lead and their manager reminded them when their mandatory training was due for renewal.

Are services at this trust effective?

We rated the trust as 'requires improvement' for being effective. This was because:

- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Monitoring and review of clinical guidelines was regularly undertaken to ensure currency.
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- There was good use of clinical audit to monitor and improve performance. Where audits highlighted areas for improvement the trust developed, implemented and monitored action plans to secure improvement.
- Pain levels were assessed, recorded and monitored in all departments and effective analgesia administered.
- We saw good multidisciplinary working both within the trust and other hospitals to ensure the patient pathway was as seamless as possible.

Evidence based care and treatment

Requires improvement



Summary of findings

- The trust only achieved two of the seven organisational key performance indicators for end of life care .
- The trust participated in the 2015 End of Life Care Audit: Dying in Hospital, which replaced the NCDAH. The results published in March 2016 indicated the trust achieved six out of the eight organisational indicators. The trust had developed an action plan to address the areas for improvement highlighted in the audit.
- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Monitoring and review of clinical guidelines was regularly undertaken to ensure currency.
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- The trust participated in the National Care of the Dying Audit of Hospitals (NCDAH).
- The findings from the 2013/14 audit showed the trust in the clinical key performance indicators the trust scored 70% and above in each indicator, which was better than the national average on every indicator.
- In maternity services an evidence based practice group had been established to identify new practice and understand the research underpinning changes in care and support.
- Staff confirmed policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of the hospital's policies and procedures and these were up to date and reflected national guidelines.

Patient outcomes

- The national myocardial ischaemia (heart attack or MINAP) audit data showed some internal improvement on the previous year but was below the England average on all three measures. There was an action plan in place to improve against the MINAP standards audit data that was overseen by the senior cardiologist and directorate lead.
- There was an action plan in place to improve against the NELA standards that had not been fully achieved, such as liaising with the medical services to support the standard for routine daily input from elderly medicine, to optimise dietician input on the surgical wards and a review of the emergency on-call consultant cover to ensure timely review of patients.

Summary of findings

- The trust had a clinical audit policy and clinical audit primary and secondary action plans.
- There were good examples of robust systems in place for consistently auditing and monitoring improvement on the safe delivery and quality of care through divisional managers, ward managers and matrons.
- The national hip fracture audit 2015 showed that the hospital performed better than the England average for six out of the 10 indicators, including the number of patients admitted to orthopaedic care within four hours, the number of patients developing pressure ulcers, bone health and falls assessments and the total the length of patient stay at the hospital.
- The audit showed 81.7% of patients received pre-operative assessment by a geriatrician compared with England average of 85.3%. The clinical director for surgery told us that ortho-geriatrician cover was put in place for weekends approximately 10 months ago and this is expected to lead to improved compliance with this measure in the next hip fracture audit.
- The national bowel cancer audit of 2015 showed that the hospital performed similar to the England average and was rated 'good' for case ascertainment rate and data completeness.
- The national emergency laparotomy audit (NELA) 2016 showed the hospital achieved 'amber' (50-69%) compliance for six out of the 10 standards and achieved 'red' (0-49%) compliance for the remaining two standards; pre-operative review by consultant surgeon and anaesthetist and assessment by a medicine for care of the older person (MCOP) specialist.
- The most recently validated ICNARC (critical care) data showed that the risk adjusted mortality ratio was 1.12 and within the expected range for comparable units.
- The latest ICNARC data showed that the unplanned readmission rate within 48 hours was within expected limits if slightly higher at 1.8% than for similar units (1.3%).

Pain Relief

- There was a dedicated pain team within the trust and staff knew how to contact them for advice and treatment when required. The trust had a pain management governance group, which met monthly.
- We found that pain relief was managed on an individual patient basis and was regularly monitored and recorded by nursing staff.

Summary of findings

- In surgical services patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- In urgent care we observed that pain relief was routinely offered on triage and recorded to walk in patients experiencing pain.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain.
- The children's unit used age dependant pain assessment tools. For younger children, a faces pain rating scale was used and for older, children pain was assessed using a number scoring system.
- Visual observation and anticipatory prescribing of sucrose was used on the neonatal unit prior to procedures taking place.
- The end of life service developed and implemented a pain relief algorithm pathway within the end of life symptom control guidance for anticipatory medication.
- The staff also reviewed previous pain scores to highlight potential early warning signs of risks.
- Patients we spoke with told us that they had access to regular pain relief.

Multidisciplinary working

- On our inspection we found multidisciplinary team (MDT) working was well established on the wards. MDT meetings took place regularly and were attended by the medical staff, nursing staff and therapy staff such as a physiotherapist and occupational therapist and social services.
- The end of life care facilitator worked closely with the community end of life facilitator with the aim of providing a seamless service between the community and the trust.
- Staff told us there was a good working relationship between the HSPC team, the bereavement centre staff, and mortuary staff.
- In radiology, the trust was working with radiologists in a neighbouring trust under the "Healthier Together" programme in order to fulfil a seven day rota. As some patients were to receive their surgery at the neighbouring trust, it made sense for their diagnostic tests to be carried out there also.
- The trust was effectively using the expertise of specialists in other hospitals to improve their patients' care.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards (DoLS)

Summary of findings

- There was a trust-wide safeguarding lead that provided support and guidance for staff with mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.
- The trust's safeguarding and deprivation of liberty safeguarding (DoLS) leads were aware of issues relating to the low completion rates of MCA assessments across the trust. The leads were working to increase awareness, to support staff in carrying out assessments, and to check DoLS application forms. As a result there had been a gradual improvement; however, the leads recognised that more work needed to be done to embed MCA assessment and DoLS applications across the trust.
- Nursing and medical staff told us that they had completed training in assessing the mental capacity of patients prior to consenting treatment. Staff were able to tell us about holding multidisciplinary best interest reviews to decide the best course of action where a patient lacked capacity. Carers and relatives were involved in the decision making process where appropriate.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.
- We observed the procedure of obtaining written consent for a child going to theatre and accompanied them to the anaesthetic room where we observed this reviewed again by the doctor, parent and child.

Hydration and Nutrition

- The trust used the Malnutrition Universal Screening Tool (MUST) scores had to identify patients who needed support with nutrition and hydration
- Patient records included these assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- There was regular dietician involvement with both adult patients and children who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the wards used a red tray system so patients requiring assistance could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Summary of findings

- The trust had attained baby friendly status level 3. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and were supported in their chosen feeding method.

Are services at this trust caring?

We rated the trust as 'good' for being caring. This was because:

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff in all disciplines treated people with dignity and respect.
- Patients were very positive about their interactions with staff. Patients felt staff had a helpful and positive attitude to their work and sought to provide them with a good experience.
- Staff were open, friendly and helpful.
- Meeting people's emotional needs was recognised as important by staff and staff were sensitive and compassionate in supporting patients and those close to them during difficult and stressful periods.
- Staff actively involved patients and those close to them in all aspects of their care and treatment. Patients felt included and valued by the staff team.
- Patients and those close to them understood their treatment and the choices available to them. Patients felt that staff took time to answer their questions and explain matters in language they could understand.
- Patient feedback from the NHS Friends and Family Test between April 2015 and July 2016 showed that the trust performed in line or above the England average. This showed that most patients were positive about recommending the trust services to friends and family.

Compassionate care

- We observed staff treating patients with kindness and compassion during all interactions. Staff took time to interact with patients and treated them with dignity and respect. There were private rooms available where staff could speak to patients privately, if required, in order to maintain confidentiality.
- We received positive comments from patients about the care they received from staff. We were told by patients that care was "very good" and that staff were "really nice" and "kind".
- On the wards we observed positive relationships between staff groups and patients with a friendly and professional rapport.

Good



Summary of findings

- The hospital had a chaperone service and patients with carers were encouraged to bring their carer to appointments to provide them with support .
- The trust had developed a butterfly symbol which they would place curtains or bed areas.
- This alerted other staff that patients relatives were spending time with them as they were at the end of life.
- End of life care was personalised and staff supported patients in achieving their wishes and aspirations as far as possible.
- The NHS Friends and Family test (FFT) is a satisfaction survey that measures patient's satisfaction with the healthcare they have received. We found that response rates were generally higher than the national average across most departments and wards.
- Data provided by the NHS friends and family test (FFT) showed that the trust performed in line or above the England average meaning 92% of patients would recommend the trust to their friends and family between April 2015 and March 2016.

However,

- There were mixed sex ward patients waiting on trollies in the CT scanner waiting room with outpatients. Staff had tried to address the dignity issue this presented with the use of mobile screens. However, this in turn presented a safety issue as the inpatients could not be observed at all times. Two patients that we spoke to expressed a dislike for there being inpatients waiting on trollies in the same area.

Understanding and involvement of patients and those close to them

- We observed staff treating all patients and their relatives with kindness and respect, both in person and on the telephone.
- Patients told us they were kept fully informed by doctors and nurses, that staff took time to “explain everything” and that information given was consistent.
- Information leaflets were available throughout the hospital for patients and the relatives covering a variety of topics . For example 96% of patients who responded to the Patient Satisfaction Survey conducted in May 2016 stated that they were given information about support available to them when diagnosed with cancer also patients discharged from the neonatal unit were given a pack containing leaflets from a national charity that provides support for premature babies and their families. This included information regarding local support groups.

Summary of findings

- The Patient Satisfaction Survey conducted in May 2016 received 694 responses. 93% of responders said that letters and any leaflets received regarding their appointment were clear. 95% of responders said that they felt prepared for their treatment.

Emotional support

- Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.
- Patients and relatives told us that staff supported them and they were able to voice any concerns or anxieties. One patient commented that the “nursing staff have more time for you” and that the medical staff were supportive.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.
- Staff confirmed they could access management support or counselling services after they had been involved with a distressing event. Staff were included in de-briefing sessions which were facilitated by the practice development team following traumatic events.

Are services at this trust responsive?

We rated the trust as ‘good’ for being responsive. This was because:

- The trust was working with the Healthier Together programme, this is the Greater Manchester (GM) reform programme which aims to deliver consistent standards of care across GM by reforming community and hospital based care.
- The trust, along with three other trusts (University Hospitals of South Manchester, Stockport and East Cheshire) signed a four-way partnership and memorandum of understanding to collaborate to benefit patients, improve quality of care and effective use of resources which can ‘flex’ to the needs of the local population.
- A bespoke system electronically tracked every patient with learning disabilities in the hospital which was overseen by a named lead nurse in learning disabilities.
- All patients with a learning disability were referred to the learning disabilities nurse by fax on admission.
- When patients were moved, an email would be sent to ward managers reminding them to be mindful of reasonable adjustments for that patient. Patients would also be put on a reasonable adjustments care pathway, and where necessary their carer had their own care pathway.

Good



Summary of findings

- There was a team of volunteers who provided mobility scooters by request and supervised their use throughout the trust so patients with mobility difficulties could move through the site easily. There were also volunteers who would sit with sensory impaired patients to guide them through their hospital journey on request. Volunteer help could be booked in advance by phone or at any reception desk.
- The trust had put in place and embedded a Referral to Treatment (RTT) and data quality team, with an experienced manager and team members, in response to CQC recommendations raised in previous reports and the inability of the trust to report RTT data accurately.
- The team had made visible and impressive improvements to RTT waiting times at the trust and were managing information at patient level. In terms of RTT standards the trust was now at mid-table level in terms of achieving standards and had previously been in the bottom six trusts.
- In May to June 2016, 50 extra clinics had been scheduled to prevent future backlogs.
- The cancellation of operations had improved since our last inspection across the surgical services, no non-elective (emergency) surgery operations cancelled between July 2015 and June 2016.
- NHS England data showed the number of last minute cancelled elective (planned) operations for non-clinical reasons was better than the England average from July 2015 to June 2016. The number of patients whose operations were cancelled and were treated within the 28 days was better than the England average for most of the period between January 2015 and March 2016.
- We saw evidence that all complaints were reviewed by the governance team who led on complaints in the trust to identify themes and trends.
- Relatives, staff and carers were supported and updated throughout the investigation.
- We reviewed complaints records and found that they had been appropriately documented and tracked.
- We reviewed the length of stay for each patient on the medical wards at the time of inspection, and saw that the length of stay on the wards was 3.3 days for elective stays generally shorter than the England average which was 3.9 days.

However,

Summary of findings

- The emergency department was failing to meet the Department of Health standard for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival. The trust failed to meet this target for 12 out of 12 months between April 2015 and March 2016.
- Patient flow through and out of the medical care services had improved, however outliers on surgical wards were still a frequent event.

Service planning and delivery to meet the needs of local people

- The trust currently serves a population of just over 250,000; this is expected to increase by 10% by 2033, with growth in the number of older people.
- Recognising this and some of the other difficulties experienced by the local population, deprivation is higher than average, the health of the people in Tameside is generally worse than the England average; the main poor health and well-being challenges facing the local population are heart disease, stroke, chronic obstructive airways disease, cancer and diabetes. The main underlying causes of these diseases relate to alcohol; obesity; smoking and age related issues such as frailty and dementia.
- The trust was working with the Healthier Together programme, this is the Greater Manchester (GM) reform programme which aims to deliver consistent standards of care across GM by reforming community and hospital based care.
- The trust, along with three other trusts (University Hospitals of South Manchester, Stockport and East Cheshire) signed a four-way partnership and memorandum of understanding to collaborate to benefit patients, improve quality of care and effective use of resources which can 'flex' to the needs of the local population.
- During the inspection we inspected the new intermediate care facility the Stamford unit which provided care for patients who were determined as medically fit for discharge but required support with nursing and care needs until suitable arrangements could be made for them to be safely discharged. This facility had been set up to as the trust recognised the need to provide a better environment for frail patients who were waiting for discharge packages but did not require an acute hospital bed.

Meeting people's individual needs

- For patients with learning disabilities the trust utilised a hospital passports.

Summary of findings

- Identified patients on the Lorenzo electronic system.
- A discreet traffic light sticker was attached on paper notes.
- A bespoke system electronically tracked every patient with learning disabilities in the hospital which was overseen by a named lead nurse in learning disabilities.
- All patients with a learning disability were referred to the learning disabilities nurse by fax on admission.
- When patients were moved, an email would be sent to ward managers reminding them to be mindful of reasonable adjustments for that patient. Patients would also be put on a reasonable adjustments care pathway, and where necessary their carer had their own care pathway.
- We reviewed one set of patient notes where we found that reasonable adjustments care plans were clearly recorded, all flagging systems appropriately noted and there was evidence these had been reviewed and updated on a regular basis.
- If patients presented behaviours consistent with dementia or a learning disability then they would be assessed during their admission to the hospital. We saw an example of this where a patient on the post-operative unit (POU) had been appropriately identified and assessed for dementia on the ward, deprivation of liberty (DoLS) measures applied and a 'this is me' passport completed.
- Staff told us there was no mandatory training concerning disabilities specifically, only an equality & diversity e-learning. There was training available in dementia and learning disabilities, however uptake was largely dependent upon the likelihood of staff to interact with these patient groups, for example auxiliary nurses on general medical wards had a higher uptake than their counterparts on maternity wards. The learning disabilities nurse said there were plans in place to roll out bespoke learning disabilities training. The trust currently relied on third sector organisations to provide training as an option for interested staff.

However,

- Trust wide, there was no specific flagging system in place to record communication or mobility needs as required by the NHS accessible information standard. There were local arrangements in different departments but nothing consistent.
- We saw that the reasonable adjustments care plans were not applied to patients with a disability other than dementia or a learning disability.

Reasonable adjustments

Summary of findings

- The main Hartshead building was designed with input from a disabled patient user group. Access to the hospital was clear and well signposted. Access ramps were available in all areas, automatic doors present, and there was a bus stop directly outside the main entrance which meant that patients could easily access public transport.
- There was a team of volunteers who provided mobility scooters by request and supervised their use throughout the trust so patients with mobility difficulties could move through the site easily. There were also volunteers who would sit with sensory impaired patients to guide them through their hospital journey on request. Volunteer help could be booked in advance by phone or at any reception desk.
- Easily accessible disabled toilets were provided in all the areas we visited. In children's outpatients there was a sensory play area for children with disabilities ranging from autism to sensory impairment. In the reception areas we saw there were low-height desks to facilitate communication with patients who had use of a wheelchair.
- In the patient advice and liaison service, information was available in a wide variety of formats such as Braille, learning disabilities-friendly and podcast. The hospital had a dedicated information service desk at the main entrance where all information could be sourced in suitable formats for patients on request.
- There were British sign language interpreters available on request from a third sector organisation; however staff told us that on some wards there were colleagues who were trained in British sign language and that for "the significant majority of cases" they felt that there was a carer present to facilitate communication. Hearing loops were available on most wards and reception areas; however there were still some departments where this was not provided, such as the post-operative unit and the maternity department.
- For patients with learning disabilities and dementia, the trust offered 'first and last' appointments in order to reduce stress and ensure minimum time spent in waiting areas. Staff told us that where they could they would make efforts to fast track patients through the process from admission to discharge.
- The trust had two wards designed for dementia patients which included dementia friendly 'reminiscence rooms'. Material and information was also available throughout the rest of the hospital, such as 'twiddle-muffs' to keep patients occupied and engaged. Every ward we saw had a comprehensive information board on dementia with contact details for the admiral nurse;

Summary of findings

however, there were no set activities for dementia patients at the time of inspection. A ward manager on one of the dementia wards told us there were plans to propose a business case for a dedicated activities assistant.

- The trust hosted a monthly 'dementia friends' café in which a multidisciplinary team provided peer support, financial advice and clinical support for carers and patients.
- We saw that each ward we visited had a comprehensive package of learning disability information for staff which included picture cards to improve communication, easy read complaints information and exit survey, contact information and copies of care pathways. This information was designed in partnership and with scrutiny from the local learning disability patients shadow board. We saw evidence that communication cards were used in interactions with staff, and both carers and staff told us that staff would take the lead from carers in getting to know the patient better.

Access and flow

- Access and flow of patients through the hospital remained a challenge in some departments particularly urgent and emergency care and medical services.
- From March 2015 to April 2016, the trust did not meet the standard for emergency departments to admit, transfer or discharge patients within four hours of arrival.
- From April 2015 to March 2016, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was reported as being above the England average for nine out of 12 months. Also data showed the percentage of patients leaving before being seen was consistently worse than the England average for the 12 month period between March 2015 and April 2016 and from March 2015 to April 2016, the total time patients spent in the emergency department (average per patient) was consistently worse than the England average.
- This means that on average patients waited more time when being admitted to hospital than in other trusts of a similar size in England.
- We found that the actions set out in the escalation process to be used in times of increased pressure were followed by the urgent and emergency care team.
- There were bed meetings held three times a day and the multidisciplinary team met regularly throughout the day to review patient care, and plan for discharge.

Summary of findings

- Data supplied by the trust showed that 526 medical services patients were placed on surgical wards between February and July 2016.
- Length of stay medical wards was 3.3 days for elective stays generally shorter than the England average, which was 3.9 days. In terms of non-elective stays the rates were similar to the England average at 6.8 days compared to 6.7 at an English level.
- The overall hospital-wide bed occupancy rate between September 2014 and March 2016 range was approximately 90%.
- NHS England data showed the number of last minute cancelled elective (planned) operations for non-clinical reasons was better than the England average from July 2015 to June 2016. The number of patients whose operations were cancelled and were treated within the 28 days was better than the England average for most of the period between January 2015 and March 2016.
- There were 467 elective operations cancelled between July 2015 and June 2016. This included 224 cancellations prior to day of surgery and 243 operations that were cancelled on the day of surgery.
- This was an improving picture from our previous inspection.
- The 'Home First' initiative was being piloted in the planned orthopaedic unit. The initiative was based on an integrated urgent care team consisting of health, social care and voluntary sector professionals that facilitated patients to have their care requirements met within their own place of residence, where possible.
- NHS England data showed the hospital performed better than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and March 2016 for all surgical specialties except trauma and orthopaedics (71.3% compared with the average of 72.3%).
- A number of actions had been taken to improve compliance with RTT standards for trauma and orthopaedics. This included an increase in consultant numbers and new theatre timetables to enable consultants to have the capacity for their procedures.
- Most recently validated ICNARC data for the period April 2015 to March 2016, showed there was an issue with out of hours discharges. Out of hours discharges are defined as 'unit survivors discharged between 22.00 and 06.59'. For the reported period the numbers were relatively low at 20 but as a percentage of eligible admissions the rate was 7.4%. This performance was poorer than similar units (3.8%). This issue was also noted in the GMCCN report of May 2016 and the unit was recommended to undertake root cause analysis of any out of hours discharges. The trust had start this work.

Summary of findings

- In terms of delayed discharges, for the same period the critical care unit's performance was better than similar units. The percentage of bed days of care for patients for whom discharge had been agreed more than eight hours ago was 1.5% against 5.4% for similar units.
- Bed occupancy on the maternity unit had been above the England average for the last 18 months however the highest it has been was 73%.
- The maternity unit had been closed six times between October 2015 and March 2016.
- Data from the trust indicated that between January 2016 and June 2016 93.9% to 97% of patients referred to paediatric services were seen within 18 weeks.
- End of life patients with cancer were accepted if they had complex pain and symptom management needs, complex psychological distress needs, required assessment for hospice admission, or had a palliative emergency at weekends. Non-cancer patients were accepted for complex end of life care.
- The palliative clinical nurse specialist team reported an approximate 73% achievement of responding to urgent referrals within 24 hours.
- In 2015/16, 185 end of life care patients were discharged from the hospital to Willow Wood Hospice. This represented a 110% increase since 2012/13 when 88 patients were transferred. Arrangements were in place for the rapid discharge of end of life care patients from the medical assessment unit to Willow Wood Hospice within 24 hours.
- An agreement was in place with the North West Ambulance Service for rapid transfer of end of life patients from the hospital to Willow Wood Hospice. Bed was available at the hospice, it was possible to transfer a patient within two hours.
- The trust had put in place and embedded a Referral to Treatment (RTT) and data quality team, with an experienced manager and team members, in response to CQC recommendations raised in previous reports and the inability of the trust to report RTT data accurately.
- The team had made visible and impressive improvements to RTT waiting times at the trust and were managing information at patient level. In terms of RTT standards the trust was now at mid-table level in terms of achieving standards and had previously been in the bottom six trusts.
- In May to June 2016, 50 extra clinics had been scheduled to prevent future backlogs.

Summary of findings

- Diagnostic waiting times in the trust were consistently better than the England average for the percentage of patients waiting more than six weeks for diagnostic results. For example, in April 2016, just under 1% of patients waited longer than six weeks whilst the England average was around 1.8%.
- There had been improvements in radiology reporting times for non-urgent outpatient requests from 55.4% reported in less than 24 hours in November 2015 to 86.2% in April 2016.
- Did Not Attend (DNA) rates remained an issue for the trust that had a target of 9.5% DNA rates. In adult clinics the DNA rate was 10% overall and in paediatric clinics the overall DNA rate was 16%.
- The trust were trialling a full booking service for paediatrics so that every parent or carer was spoken to and text reminder scripts were being reviewed. The call centre was staying open until 6pm two times per week and call centre staff had ring back lists so they could keep trying to contact patients to remind them of appointment times. We were assured that the trust were very proactive in seeking solutions to problems identified with DNA rates.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns.
- These included defining who was responsible for managing complaints, the timescales for investigations and responses to complainants and the governance pathways through which complaints were reported from ward to board.
- Learning from complaints, concerns and compliments was triangulated within the divisions feedback was via multi-disciplinary and team meetings.
- The trust's website contained information on how to raise a concern both informally and as a formal complaint.
- The noticeboards throughout hospital displayed a range of helpful and supportive information and contact details, including how to make a complaint or raise a concern.
- There was also information on how to raise a complaint and contact details of the patients advice and liaison service (PALS) team was prominently displayed around the hospital.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient.
- We saw evidence that all complaints were reviewed by the governance team who led on complaints in the trust to identify themes and trends.

Summary of findings

- Relatives, staff and carers were supported and updated throughout the investigation.
- We reviewed complaints records and found that they had been appropriately documented and tracked.
- Complaint had been responded to in a timely manner and apologies had been offered, where appropriate.
- Information about complaints was discussed during staff meetings to facilitate learning.
- Meeting minutes showed there was oversight and scrutiny via the trust governance committee where trends and themes were discussed.

Are services at this trust well-led?

We saw good leadership across the trust at all levels. The executive teams had sustained progress since our last visit. Staff we spoke to were highly engaged with the trust's vision and could articulate their personal role in delivering the vision.

Staff told us that the trust executive team was very visible and had a lot of contact with staff. We heard from staff that it was common place to see the chief executive in clinical areas.

We saw strong governance arrangements that were effective. We reviewed the trust's fit and proper person requirement processes and found them to be compliant. We saw programmes that showed the trust was engaging with its local community.

Leadership of the trust

- The trust executive described, and we saw in practice, that the staff were sighted on the new model of working. The leadership of the organisation was strong in promoting engagement in new models of working.
- Staff reported that leadership in clinical areas was good. Local leaders were clear on what was required and staff felt well supported.
- We saw evidence of clear oversight from local leaders on the quality of the service provided to patients.
- Local managers told us that the trust executive team was very visible and had a lot of contact with staff when changes were planned.
- When we asked the chairman what he was proud of, he replied that: "now people tell me what is right with the hospital; not what is wrong with it".
- Staff told us that the culture is no longer 'us and them' now it's 'we'.

Vision and strategy

Good



Summary of findings

- The trust's aim was 'to deliver, with our partners, safe, effective and personal care, which you can trust'. This was underpinned by a set of values and behaviours that were based on safety, care, respect, communication and learning.
- The corporate objectives 2015/16 listed seven key objectives, including providing harm free care, to improve the patient experience and to develop a continuous quality improvement culture.
- The corporate objectives had been incorporated into key priorities within the surgical services. The surgical services strategy 2015/16 listed a number of key objectives based on providing safe and high quality clinical services for patients, to achieve financial stability, to enhance patient experience and quality of care and to work effectively with strategic partners.
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.
- The chairman described a clear strategy for the hospital as part of the health and social care system. He described good working relations with local authority and other care providers. As evidence he described on going discussions to have a base room in the ED for a local police officer so cases of abuse can be reported and self-reported.
- The chairman was invited to and attended the Clinical Commissioning Group (CCG) meetings. He described how issues identified at CCG board meetings were shared back via the trust management for action and consideration.
- The medical director now attended the GP area team meetings to improve communications.
- Staff we spoke to understood the vision and purpose of the trust.

Governance, risk management and quality measurement

- The chairman described the 'temperature test' by non-executive directors during walkabouts. They used this process to seek assurance of the formal messages they had heard in board and committees.
- Risk registers were in place, and they reflected the issues identified in clinical areas.
- In service areas, regular staff meetings were held which discussed challenges in delivery and also shared information on complaints, incidents and audit results.
- Clinical dashboards were in use to demonstrate monitoring and awareness of these data.

Summary of findings

- Dashboard data was available to all managers for other wards. This allowed local leaders to monitor progress against others and benchmark their own position.
- The trust had adopted a strong approach to governance and management of risk. The trust had a governance team that showed strong leadership in the management of risk and governance processes.
- The director of governance was clearly sighted on complaints, issues in the services and processes for responding to concerns. There was a clear line of sight to the board and regular and detailed discussions were held to ensure the board were focused on the challenges that required their input. We saw that the CEO and the director of governance had a good working relationship to ensure these issues were openly discussed.
- We observed that following our last inspection, the trust had taken clear action on the issues we had raised. An action plan was prepared and had become a focus in the organisation.
- The trust set high standards of staff performance and expectations. We saw that the trust upheld these standards. Staff respected this and valued the clarity. Many saw the 'raising standards' as 'the way we do things round here now' and attributed progress to this change in quality.

Culture within the trust

- Local managers told us that the trust executive team was very visible and had a lot of contact with staff when changes were planned.
- Staff at all levels and roles said that everyone was helpful and staff were supportive of each other for the benefit of patients.
- Medical staff reported a positive change in culture.
- Newly appointed staff told us that Tameside hospital was more personal than larger hospitals they had worked in.
- We saw a genuine passion for improvement within individuals and teams across the organisation. People recognised there was still much work to do; but expressed solidarity in their efforts to achieve it.
- We saw that this strong culture to improve extended from the board through to the patient interface and amongst non-clinical staff too.

Fit and Proper Persons

- We reviewed the trusts processes and found them to be compliant.
- The process for preparing for the FPPR had begun in July 2014.

Summary of findings

- The chair had written (February 2015), to all existing executive and non-executive directors and asked them to complete a self-declaration. This covered all the appropriate points of the fit and proper persons requirement (FPPR). In all 18 individuals were asked to complete the declaration and 18 responses (including the date returned) were logged. We looked at examples of these and saw they were well completed.
- We saw that the company secretary had (on behalf of the chairman) undertaken a companies house search of each individual to see they were not barred from holding office. The results of these were well recorded.
- We saw that this process would be repeated every year with a full review every three years.
- We reviewed the files of two directors selected at random (one non-executive and one executive). We found the checks to be fully completed and fully documented. Where members had started employment since fit and proper persons requirement was identified; this was also written in to their contract of employment.
- A full DBS check was undertaken for all staff.

Public engagement

- On 9 May 2015 the first in a series of new community events was hosted by the trust. The aim of the event was to bring the hospital's consultants, nurses and healthcare professionals into the heart of the Tameside community to discuss and educate the public on specific conditions.
- We saw evidence of a number of community events reaching out to the public with information and support. One planned for just after our inspection visit was for people living with dementia.
- In surgery, staff sought feedback from patients by asking them to complete a feedback survey. The survey covered key areas such as staff courtesy, privacy and dignity, cleanliness, medication and discharge processes. The information was used to look for possible improvements to the service.

Staff engagement

- Staff at all levels were committed to improving the service and felt engaged with the changes that had been made and what still needed to be achieved.
- Staff told us they received good support and regular communication from their line managers.

Innovation, improvement and sustainability

Summary of findings

- One member of staff said she had previously felt like a “Jack-in-the-box; speak up with a new idea and the lid was pushed down”. Now they told us that they felt they can offer innovation, speak out and they would be listened to. They told us they felt empowered.
- In the emergency department they had introduced a nurse led REACT service to try and reduce handover times from the ambulance service.
- Partnership working with the local police force had produced a range of initiatives to ensure that complex cases with a mental health condition or high-risk cases were appropriately and safely managed. A ‘Missing Patients Guidance’ had been produced to reduce the number of missing patients leaving the hospital.
- In ED, a librarian attended the board rounds. They accessed evidence-based research to feedback to questions posed by the trainee doctors. This information was then published on the ED webpage.

Overview of ratings

Our ratings for Tameside Hospital

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

Our ratings for Tameside Hospital NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

Urgent and Emergency Services

- The department's practice development nurse provided excellent support and education to the staff within the department.
- The department's handling of the major incident, which occurred during the inspection, was excellent and ensured that patients were treated in the most appropriate and safe manner.
- The divisional leaders made great efforts to ensure that they were visible at all times, especially during times of pressure.

Surgical Services

- Ward staff applied 'reasonable adjustment' principles for patients with learning disabilities and specific care plans were in place to provide guidance for staff. The care plans took into account factors such as the environment, communication (e.g. use of communication books or easy read leaflets), staffing, equipment requirements and procedures (such as booking patient first or last on list).

Maternity and gynaecology

- A programme for supporting and informing pregnant women with alcohol consumption problems had been

developed. MAMA (Maternal Alcohol Management Algorithm) was managed by the safeguarding lead midwife. This provided pathways into related services in the community including rehabilitation day services, community support and detoxification support.

End of life care

- The trust had direct access to electronic information held by community services, including GPs. This meant hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Outpatients and diagnostics

- The radiology department offered a "Virtopsy Service". This virtual post-mortem service was used when a CT scan could determine the cause of death. This speeded up the process of determining cause of death and respected the religious and cultural needs of some of the local population. Scans were carried out at night and reporters were experts in reporting on virtual post-mortems. Deceased persons were transported to the unit via a private corridor. The trust were one of the first in the North West to offer this service.

Areas for improvement

Action the trust MUST take to improve

Urgent care

- Ensure that patients can access emergency care in a timely way.
- Ensure all staff receive mandatory training at the required level and within the appropriate time frame.
- Ensure that fridges used to store medications are kept at the required temperatures and checks are completed on these fridges as per the trusts own policy.

Medical Services Including Older People

- Ensure there are appropriate numbers of nursing staff deployed to meet the needs of patients.

Children and Young People

- Ensure all equipment used to provide care or treatment to a service user is properly maintained.
- Ensure that there is one nurse on duty on the children's ward trained and up to date in Advanced Paediatric Life Support on each shift.

Action the hospital SHOULD take to improve Urgent and emergency care

- Ensure that staff receive their annual appraisal.

Medical services including Older people

Outstanding practice and areas for improvement

- Ensure children's safeguarding training was across all professions within the medical directorate is up to date.
- Look to reduce the number of medical patients being cared for on surgical wards.
- Continue to monitor staffing arrangements on wards.

Surgical Services

- Take appropriate actions to improve mandatory training compliance rates.
- Take appropriate actions to reduce the number of cancelled elective operations.

Maternity and gynaecology

- Ensure the improvements in the infection prevention and control measures and the environment on ward 27 should continue.
- Emergency medicines should be safely stored in the obstetric theatre in line with trust's policy for the safe use of emergency medicines.
- Records should be securely stored in the ward areas.
- Appropriate actions should be taken to improve the mandatory training compliance rates including the safeguarding training.
- Ensure that a deteriorating patient's care was managed in line with the trust's policy.
- Continue to make improvements in the completion of the safer surgery checklists.
- Develop a system to ensure patients received required home visits by the community midwives.

Children and Young People

- Ensure recording of fridge checks include the maximum and minimum temperatures in accordance with national guidance.
- Ensure dates of cleaning and safety checks are legible on equipment.
- Review documentation for infants when intervention is reduced to high dependency or special care.
- Ensure the security and confidentiality of medical records in the paediatric outpatients department.
- Ensure PEWS documentation is completed and audited to improve compliance.
- Ensure the neonatal unit consistently collect patient feedback using the NHS Friends and Family Test.
- Ensure inpatient discharge summaries and outpatient clinic letters are sent in a timely way.

- Ensure regular staff meetings take place on the neonatal unit.

End of life care

- Consider how it can increase uptake of the use of the individual care plan for end of life care patients.
- Consider how it can encourage improvement in the accuracy and completeness of DNACPR forms, including the undertaking and recording of mental capacity act assessments, the recording of best interests decisions, and discussions with patients and their relatives.
- Consider reviewing information held within the palliative rapid discharge link nurse files held in wards and units across the trust to ensure the information held is accurate, up to date, and in line with prescribing and dosage guidelines for anticipatory medicines.
- Consider what actions it could take to further increase the proportion of end of life care patients dying in their preferred place of care.
- Consider what actions it can take, within its control and where requested, to increase the percentage of end of life care patients discharged within the timescales of the rapid and fast discharge process.

Outpatients and Diagnostics

- Continue the active recruitment of radiologists to meet actual WTE requirements and maintain safe staffing levels.
- Resolve the issue of allied health professionals being unable to accurately record mandatory training levels.
- Carry out an infection control risk review of positioning aids foam pads in radiology, to ensure that the risk of infection is minimised.
- Ensure that all entries on patient notes are signed and dated.
- Continue to increase the numbers of staff who have undertaken child safeguarding training to meet trust targets.
- Review version controls on Local Rules for Radiation Protection and ensure that all staff have signed them to indicate that they have read and understood them.
- Continue to seek a solution to the lack of an electronic system that interfaces with local GP surgeries.
- Continue to seek viable solutions to reduce "Did Not Attend" (DNA) rates.

Outstanding practice and areas for improvement

- Continue to seek solutions to improve “Referral to Treatment” (RTT) times so that all clinical pathways met national standards.
- Review the consultation room in clinic nine where the door opens outwards to improve privacy and dignity for patients.
- Review the children’s play area in outpatients clinics six to nine to see whether this could be better located or children observed and kept safer.
- Improve patient knowledge of how to access PALS should they need to do so.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment.</p> <p>Care and treatment was not always provided in a safe way in that the risks to the health and safety of patients was not always assessed and mitigated.</p> <p>This is because patient flow throughout the hospital was an ongoing challenge, particularly in A&E and medical care. Due to continual bed pressures there were occasions when patients had been transferred from the Acute Medical Unit during the night and medical outliers were still common place. This meant that some patients were not placed in the area best suited to their needs. There were also long delays in A&E.</p> <p>HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (a) (b)</p>