The Pennine Acute Hospitals NHS Trust

Fairfield General Hospital

Quality Report

Rochdale Old Road
Bury
BL9 7TD
Tel: 0161 624 0420
Website: www.pat.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Fairfield General Hospital is one of the locations providing inpatient care as part of The Pennine Acute NHS Trust. It provides a range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, and a range of outpatient and diagnostic imaging services.

The Pennine Acute NHS Trust provides services for around 820,000 people in and around the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham, Rochdale and parts of East Lancashire. There are approximately 1191 inpatient beds across the Trust with The Fairfield General Hospital having approximately 236 inpatient beds.

We carried out an announced inspection of The Fairfield General Hospital between the 23 to the 3rd March 2016 as part of our comprehensive inspection of The Pennine Acute Trust.

Overall, we rated The Fairfield General Hospital as Requiring improvement. We found that the services were provided by dedicated, caring staff, and patients were treated with dignity and respect. However, improvements were needed to ensure that all services were safe, effective, well led and responsive to people's needs.

Leadership and Management

- There was clear leadership and communication in services at a local level, senior managers were visible, approachable, and staff were supported in the workplace.
- There was a positive culture throughout teams in the hospital and staff were committed to being part of the trusts vision and strategy going forward.
- Managers also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- We observed there was currently no trustwide clinical lead in Pathology Services, however recruitment was underway.

Access and Flow

- Access and flow remained a challenge in the emergency department. Records showed that between April 2015 and February 2016, the department achieved the 95% target in only five weeks during this period. The monthly percentage of patients seen within four hours of arrival ranged between 74.35% and 97.12%, with an overall average of 84.61% of patients seen within four hours during this period.
- The average time to treatment was consistently worse than the 60 minute Department of Health standard between October 2015 and February 2016.
- Between October 2015 and December 2015, the average occupancy rate at the hospital was 94%,
- There were challenges with access and flow across medical ward which resulted in patients being moved multiple times, of which some were undertaken outside of normal working hours. In the period November 2014 to October 2015, 45% of patients experienced multiple ward moves during their stay. Information provided by the trust showed that between April 2015 and September 2015, the number of patients on medical wards that were transferred to another ward after 10pm at night was high for the emergency admissions unit which averaged around 126 a month.
- Some medical patients were being nursed in non-speciality beds but to access and flow pressures. Between November 2014 and October 2015 there had been 173 outliers at the hospital.
- The hospital met the 18 week referral times for 95.6% of patients as at 11 February 2016 and this included medical treatment, which was better than the national target of 92%.

Summary of findings

- Access and flow challenges impacted upon patients being delayed from being discharged from critical care. Between January and June 2015, 55 patients had experienced delays, however most delays were less than 24 hours.
- There were processes in place to support patients reaching the end of life bring transferred to their preferred place of care within 24 hours, including a rapid transfer arrangements.
- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average and the cancer waiting times for the trust were consistently better than the England average we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level. Work is being undertaken with the trust to clarify the current position.

Cleanliness and Infection control

- The trust had infection prevention and control policies in place, which were accessible to staff and staff were knowledgeable on preventing infection.
- Clinical areas were visibly clean, and there were were processes in place to maintain standards of cleanliness.
- There was enough personal protective equipment available, which was accessible for staff and staff used this appropriately.
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- Between April 2015 to December 2015, there were no case of MRSA bacteraemia reported across the hospital.

Nurse Staffing

- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements. As part of this, key objectives were set though this work to support safer staffing.
- We found that there were not always sufficient numbers of trained nursing staff in the emergency department to meet patients' needs, as the existing establishment did not always have the flexibility to cope with the number of patients attending the department.
- Nurse staffing levels on medical wards overall met the needs of patients; however, there had been a reliance on temporary staff on the some of the wards.
- There had been a decrease within the specialist palliative care team which meant patients did not have appropriate access to specialist care and treatment from this team on Mondays or at weekends.
- Staffing information was available for patients and the public on a boards at the entrance to wards..
- Pressures in nurse staffing meant that the critical care unit did not always meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7.

Mortality Rates

- Mortality and morbidity meetings were held on a monthly basis. Meeting minutes showed that actions and learning were identified but it wasn't always clear who was responsible for their implementation or the timeframe that it would be expected in.
- 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 SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. In September 2014 the hospital score was 106.8. Actions had been put in place to improve the outcome for patients. These included review of the care pathway and further end of life training for staff.

Summary of findings

- Within critical care, mortality and length of stay for ventilated admissions and patients with severe sepis was higher than in similar units.

Nutrition and Hydration

- Patients had access to food and drink whilst in emergency and outpatient departments.
- We found that there were policies and procedures in place to support patients nutritional and hydration needs. Patients nutritional needs were risk assessed and results were acted upon appropriately.
- Patient received assessments of their nutritional requirements using the malnutrition universal screening tool (MUST), which highlighted if they were at risk of dehydration or malnutrition. However, audits undertaken across medical wards showed that this assessment was not always completed.
- A variety of food choices was available to patients. Special diets, for example diabetic, gluten free, renal, soft textured and allergy diets were available.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the hospital must:

Emergency and Urgent Care

- Take appropriate actions to improve nursing and medical staffing levels.
- Take appropriate actions so that patients attending the department are assessed and treated in a timely manner.

Medical Services

- Ensure that records are kept secure at all times so that they are only accessed by authorised people.
- Ensure that all staff are aware of the procedures for capacity assessments and these are completed where necessary
- Ensure that assessments of patient's nutrition and hydration needs are fully completed and patient's receive appropriate support where necessary
- Ensure that the discharge lounge and ambulatory care unit is fit for purpose and patients supported to have conversations about their care where they cannot be overheard.

End of life care

- Ensure that the DNACPR procedure is always completed in accordance with the accepted legal requirement to either gain the patient's consent, or where a patient lacks capacity, following a discussion with the patient's family.
- Ensure that where a patient lacks capacity to make a decision about DNACPR, a mental capacity assessment has been carried out.
- Ensure that it takes action to ensure the DNACPR documentation is always completed in line with its own policy.

In addition the hospital should:

Emergency and Urgent Care

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

Medical Services

- Consider that rooms used to care for patients who have an infection are managed appropriately
- Consider that patients are discharged as soon as they are fit to do so.

Summary of findings

- Consider that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.
- Consider that patient pain is consistently recorded
- Consider that all staff seek consent for the use of bedrails and if they lack capacity apply the Mental Capacity Act (2005) principals and this is reflected in procedures.

Surgical Services

- Consider embedding a recognised early warning system which gives clear and unambiguous guidance on escalation procedures and care for the deteriorating patient.
- Consider the recording and disposal of controlled drugs where the whole of one vial is not prescribed, is in line with trust and Royal Pharmaceutical Society of Great Britain guidance.
- Consider implementing a pracise where no arrest trolleys are padlocked, but that they are sealed with unique reference number tags as per trust policy.
- Consider ensuring doctors' handwriting is legible, particularly on important documents such as consent forms and the detailing of side effects of surgery.
- Consider that in the anaesthesia and surgery divisionthey are compliant with all elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- Consider that they take steps to improve compliance with the recommendations of the British Orthopaedic Association standards for Trauma (BOAST) to prevent patients waiting longer than 72 hours before seeing an orthopaedic specialist.
- Consider that the division take steps to address their very high readmission rates.
- Consider ensuring they work towards compliance with all of the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Consider taking steps to improve theatre utilisation.

End of Life care

- Consider a full review of the staffing requirements to introduce seven day specialist palliative care services at the hospital.
- Consider how to respond to the complex symptom control needs of EOL patients out of hours.
- Consider how to provide training to middle grade doctors about the complex symptom control needs of EOL patients.
- Consider whether the current SPCT staffing levels are sufficient to meet the current demands on the service.
- Consider how to involve SPCT in the service developments required to implement the EOL strategy.
- Consider the level of support and education required from EOLC facilitation team for FGH to embed the use of the IPOC documentation across all its wards.
- Consider how to develop a sensitive tool to ascertain when incidents occur related to EOL issues.
- Consider how to provide SPCT staff with feedback from incidents submitted to enable action to be taken to prevent such incidents reoccurring.

Outpatients and Diagnostics

Summary of findings

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We judged urgent and emergency services at Fairfield Hospital as requires improvement overall because:

- Patients attending the department experienced extended delays before they received treatment.
- The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival
- The average time to treatment was consistently worse than the 60 minute DH standard between October 2015 and February 2016.
- There were six instances where patients had trolley waits of more than 12 hours between November 2015 and February 2016.
- The department failed to achieve targets for ambulance handover within 15 minutes between April 2015 and January 2016. There were 122 ambulance handovers that took longer than 60 minutes (black breaches)
- There were vacancies in the medical, nursing and healthcare support worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. .
- The main reasons for these delays was due to insufficient bed capacity across the hospital, which meant patients that required admission could not be transferred to the wards in a timely manner.
- The completion rates for mandatory training in the department were below the trusts expected level of 90%. Complaints were not routinely resolved within the trusts specified timelines.
- The department last participated in the CEM audit for severe sepsis and septic shock during 2011/12. We did not see any evidence to demonstrate how the department planned to improve compliance against the sepsis audit or how compliance was monitored since this audit.
- There was no formal strategy specifically for the service.

Summary of findings

- The patient satisfaction surveys showed the department scored worse that the England average for the number of patients that would recommend the emergency department to friends and family.

However, : -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- Care and treatment was provided in line with national clinical guidelines.
- Patients spoke positively about their care and treatment. There was effective local leadership and staff spoke positively about the support received.

Medical care (including older people's care)

Requires improvement

We judged medical services at Fairfield General Hospital as requires improvement overall because:

- We found standards in record keeping required improvement and records were left unsecured on the acute medical unit and ward 21.
- It was unclear if resuscitation equipment was always being checked which meant that emergency equipment might not be available when needed.
- Training levels in medicines management was low
- Staff were not always following trust policies and procedures in relation to assessing patients for capacity and in the completion of capacity assessments. Nursing staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint.
- We found there was insufficient bed capacity on occasions on the medical wards to meet the needs of people within the hospital .
- Some risks on the risk register had been there since 2011. It was unclear if all risks were managed in effective timely way to lower the risk. It was unclear if learning was shared wider across other service areas. There were times when complaints took a long time to resolve.

However,

Summary of findings

- There were systems in place to keep people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.
- Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations where findings were fed back to staff at a local level.
- There were safe systems of the handling and disposing of medications.
- The hospital was clean and staff followed good hygiene practices.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a leaf symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs.
- People were supported to raise a concern or a complaint and lessons were learnt and improvements made.
- We observed care and found this to be compassionate from all grades of support and clinical staff and patients were involved in their care and treatment.

Surgery

Requires improvement

We judged surgery at Fairfield General Hospital as requires improvement overall because;

- The early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalation of concerns for a deteriorating patient were not embedded.
- The division did not always record and dispose of controlled drugs in line with policy.
- An emergency trolley was padlocked in theatres, which could prevent quick access to it in an emergency.
- We found that in four out of ten records that we checked that the doctors' handwriting was illegible on surgery consent forms.
- There was no surgical consultant on duty at Fairfield to see medical patients who required a specialist surgical consultation.
- There were difficulties recruiting surgical doctors. There was a reliance on locum doctors.

Summary of findings

- The division had very high readmission rates, which were significantly higher (worse) than the England average.
- Theatre utilisation was low at 69.2%.
- However, we also found that;
- There was a good culture of reporting incidents and safety issues and that investigations were thorough.
- We saw evidence of learning when things went wrong and saw implementation of measures to improve quality and safety.
- We found that staff had the appropriate skills and training to enable them to keep people safe.
- The environment was clean and hygienic with low levels of healthcare associated infections.
- Patient outcomes were good and in some areas, the division performed better than other trusts and England averages.
- Staff were experienced, well trained and competent in their roles.
- The multidisciplinary team working was good with satisfactory access to a range of specialities.
- Patients told us staff were kind and respectful and that they were kept informed and involved in the care and treatment they received.
- The division achieved good friends and family test results.
- The ward environment was very good for dementia patients and many of the recommendations from dementia best practice guidance had been implemented.
- Complaints were handled and responded to appropriately and the feedback was used to improve services for patients.
- The average length of stay for surgical patients at Fairfield was lower than the England average.
- The surgery and anaesthesia division was well led both on a ward level and at divisional level.
- Managers were competent and enthusiastic about their service.
- There was a positive supportive culture throughout the wards and departments.
- Staff had seen positive changes in the last 12 months and anticipated things would continue to improve.

Summary of findings

Critical care

Requires improvement

We judged that overall the critical care service at Fairfield Hospital required some improvement. The was because

- The nurse staffing failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7.
- There was no critical care outreach service provided at Fairfield Hospital.
- The hospital was non-compliant with a number of elements of the NICE clinical guidance around the rehabilitation of critically ill patients.
- There was a problem with delayed and out of hours discharges from critical care.
- It was not clear how risks to critical care were being managed.
- The risk register reported risks that had been identified for a number of years but there was a lack of clarity about mitigating actions, progress and review.

However

- Critical care services were delivered by caring, compassionate and committed staff.
- We saw patients, their relatives and friends being treated with dignity and respect.

End of life care

Requires improvement

We judged End of life services at FGH require improvement this was because

- No specialist palliative care service is provided after 5.00pm Monday to Friday or at all at the weekends.
- There was a lack of training in symptom control for middle grade staff which compounded the lack of specialist palliative care available to patients out of hours and at the weekend.
- We observed a number of examples where completion of Do not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation did not conform to the standard set out in the trust policy.
- The individual plan of care (IOPC) replacing the Liverpool care pathway was not embedded

across FGH wards. Staff reported that they did not understand the IPOC documentation, did not feel confident using it and required more training before they would be happy to use it.

- There was no robust, sustainable strategy proposed to address the risk regarding the lack of a seven day service.
- Clinicians believed that managers did not share their passion and commitment to EOL services, because of the reduction in staffing levels and did not feel involved in decisions about the future of services at FGH.

However

- We observed care being delivered to patients, who were at the their end of life, with kindness, consideration and empathy.
- We heard from relatives who reported that they and their loved ones were treated with kindness and received professional treatment and care.
- We also, heard, observed and noted that rapid discharge services were arranged to be highly responsive to the needs and wishes of patients.

Outpatients and diagnostic imaging

Good

We judged outpatients and diagnostic imaging services as Good overall this was because

- Staff were confident about raising incidents and told us that they were encouraged to do so.
- Staffing levels were appropriate to meet patient needs although increased demand on the Radiology services meant some reporting on diagnostic imaging is outsourced overnight to ensure that turnaround times for reports are within national guidelines.
- There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of their roles and responsibilities in regard to safeguarding.

Summary of findings

        - The departments inspected were visibly clean and staff followed good practice guidance in relation to the control and prevention of infection.
    - We observed that the equipment used in the care and treatment of patient's was clean and in good work order.
- An electronic patient record system allowed the filtering out of relevant information and facilitated information being available to different teams very quickly.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff who treated people with dignity and respect
- Departmental managers were knowledgeable and supportive and had vision improve their services.
- Staff in outpatients and diagnostic services, demonstrated good team working (including multidisciplinary working) and were competent and well trained.

However

- Not all notes had been scanned and paper notes were still in use for some patients.

Fairfield General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Fairfield General Hospital

Fairfield General Hospital is situated in Bury and is one of the four acute hospitals that form part of Pennine Acute Hospital Trust, which looks after a population of approximately 820,000 people. There are approximately 236 inpatient beds on the site.

The hospital hosts an Accident and Emergency department.

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

The surgical services carry out a range of surgical procedures such as trauma and orthopaedics, urology, ear, nose and throat and general surgery (such as gastro-intestinal surgery).

Critical care services are provided in a six bedded unit to both two level 2 HDU and four level 3 ICU patients. There is an ability to flex the occupancy up to a maximum of five level 3 patients. In addition there is a stabilisation bay, occasionally used overnight by the advanced nurse practitioners.

The unit has one side room for the purpose of isolating patients that present an increased infection control risk. No critical care outreach service is provided at the hospital.

The trust specialist palliative and end of life care service is part of the out of hospitals directorate within the integrated and community services division of the Pennine Acute Hospitals NHS Trust. The service operates across four hospital sites (Fairfield General Hospital, North Manchester General Hospital, Rochdale Infirmary and Royal Oldham Hospital) and in the community in North Manchester. The service operates from Monday to Friday, 8.30am to 4.30pm.

There is no hospice in Manchester however the SPC team have close links with St Ann's hospice in Little Hulton, Dr Kershaw's hospice in Oldham and Springhill hospice in Rochdale.

Outpatient services provided from Fairfield General are mainly held in four departments . Diagnostic imaging services are provided. There were 152,472 outpatient appointments from July 2014 to June 2015 and 701,767 for the trust overall.

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

Detailed findings

Our inspection team

Our inspection team for the Trust was led by:

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

Head of Hospital Inspections: Ann Ford, Care Quality Commission

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following core services at Fairfield General Hospital:

- Urgent and Emergency Department
- Medical care including care for Older people
- Surgical care
- Critical Care
- Maternity and Gynaecology
- Children and Young People
- End of Life
- Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from the ward areas and outpatient services we visited. 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 received feedback through focus groups. We held a listening event on the 17th February 2016 where members of the public were invited to discuss their experience of services at Fairfield General Hospital.

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 Fairfield General Hospital

Facts and data about Fairfield General Hospital

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

In 2014/15 62,625 patients attended the urgent care department from the communities. In total the hospital has 236 beds.

The health of people in Bury is varied compared with the England average. Deprivation is lower than average, however about 16.9% (6,400) children live in poverty. Life expectancy for both men and women is lower than the England average.

Bury is ranked 87th most deprived local authority (out of 326).

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services at the hospital provided care and treatment for patients across Bury and the surrounding areas. The department had 62,625 attendances between November 2014 and November 2015 with an average weekly attendance of 1,204 during this period. 85% of patients attending the emergency department were adults and the remaining 15% were children up to 16 years of age.

Emergency services for adults were provided 24 hours a day, seven days a week. Services for children up to 16 years old were available between 9am and 9pm daily. Children attending the department outside of these hours were transferred to other hospitals.

The emergency department included separate triage and waiting areas for adults and children. There was a separate children's area with six cubicles. The resuscitation area could accommodate up to five patients. The major injuries area had 11 cubicles, including a secure mental health assessment room. There was also a minor injuries area with six cubicles.

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

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

Urgent and emergency services

Summary of findings

We rated urgent and emergency services at Fairfield Hospital as requires improvement overall because:

- Patients attending the department experienced extended delays before they received treatment.
- The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.61% during this period.
- The average time to treatment was consistently worse than the 60 minute DH standard between October 2015 and February 2016. The total time patients spent in the department was also higher than the England average during this period. There were six instances where patients had trolley waits of more than 12 hours between November 2015 and February 2016.
- The department failed to achieve targets for ambulance handover within 15 minutes between April 2015 and January 2016. There were 356 handovers that took between 30 and 60 minutes during this period. There were 122 ambulance handovers that took longer than 60 minutes (black breaches) between April 2015 and January 2016.
- There were vacancies in the medical, nursing and healthcare support worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. An independent nurse staffing review in November 2015 recommended an increase to the current establishment in order to fully meet safe staffing standards.
- The main reasons for these delays was due to insufficient bed capacity across the hospital, which meant patients that required admission could not be transferred to the wards in a timely manner. An urgent care improvement plan was in place to improve patient flow but key actions listed in the improvement plan were not scheduled for completion until August 2016.
- The completion rates for mandatory training in the department were below the trusts expected level of 90%. Complaints were not routinely resolved within the trusts specified timelines.
- The department last participated in the CEM audit for severe sepsis and septic shock during 2011/12. We did not see any evidence to demonstrate how the department planned to improve compliance against the sepsis audit or how compliance was monitored since this audit. The department was scheduled to participate in the 2016/17 audit that was due to commence in August 2016.
- The urgent care directorate was formed recently and the clinical director and lead nurse for urgent care services across the trust had been in post since December 2015 and January 2016 respectively. There was no formal strategy specifically for the service. The clinical governance system allowed key risks to be escalated and reviewed. However, the length of time taken to respond to these risks meant the department did not have a proactive approach to managing these risks.

However, we also found that: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- Care and treatment was provided in line with national clinical guidelines. The emergency and urgent care services participated in national and local clinical audits. The services performed in line with other hospitals and performed within the England average for most safety and clinical performance measures.
- Patients spoke positively about their care and treatment. There was effective local leadership and staff spoke positively about the support received.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated this service as requires improvement for safe because:

- There were vacancies in the medical, nursing and healthcare support worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. This is in breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- An independent nurse staffing review took place during November 2015 and this recommended an increase to the current establishment of band 5 nurses and band 2 support staff in order to fully meet safe staffing standards.
- The majority of staff (81%) had completed mandatory training. However, the trust target of 90% compliance had not been achieved in the department.
- The department failed to achieve the target for ambulance handover within 15 minutes between April 2015 and January 2016. There were 356 handovers that took between 30 and 60 minutes during this period. There were 122 ambulance handovers that took longer than 60 minutes (black breaches) between April 2015 and January 2016.

However:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Incidents

- The emergency department at the hospital had reported nine serious incidents to the strategic executive information system between November 2014 and February 2016. These included four incidents where patient wait times exceeded 12 hours, a patient transfer issue, three incidents of delayed diagnosis or delayed care and treatment and an incident involving inappropriate behaviour by a member of staff towards a patient.
- Records showed there were 1153 incidents reported in the department between January 2015 and December 2015. The most frequently reported incidents were 'patient absconded' (291), 'patient watch (security)' related (225) and 'patient found on floor' (68).
- We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the clinical matron or lead consultant.
- Staff told us incidents were discussed during monthly quality and performance meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at. Learning from incidents was also shared across the department via noticeboards, newsletters and at daily 'safety huddle' meetings.
- The incident reporting system identified incidents that had led to serious or moderate harm to patients and prompted staff to apply duty of candour guidelines (being open and honest with patients when things go wrong).
- Incident reports showed that duty of candour guidelines had been applied where serious had occurred. This included a formal apology to the patient and their relatives along with an explanation of the remedial steps to be taken to address the issue.
- Patient deaths were reviewed by individual consultants and were also reviewed at monthly quality and performance meetings.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections or C.difficile infections reported in the department during the past 12 months.
- The emergency department was visibly clean, tidy and maintained to a good standard. Staff were aware of

current infection prevention and control guidelines. Cleaning schedules were in place, with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Staff told us all patients admitted to the hospital were screened for MRSA. Patients identified with diarrhoea and vomiting symptoms were also screened for C.difficile. Patients with recent hospital admissions were also screened for Carbapenemase-producing Enterobacteriaceae (CPE) infections.
- Records noted patients with known infections so they could easily be identified and treated appropriately. Patients identified with an infection could be barrier nursed in the single rooms (doored cubicles) within the department or admitted to the hospital's wards if isolation facilities were required.
- Staff carried out monthly monitoring of compliance in areas such as hand washing compliance and cleanliness of the environment and equipment.
- The department achieved average compliance scores of 96% in the monthly environmental cleanliness audit and 98% in the monthly equipment cleanliness audits between April 2014 and November 2015. This was above the trust target of 90% and showed the department maintained a high level compliance with cleanliness standards.

Environment and equipment

- The emergency department was well maintained, free from clutter and provided a secure environment for treating patients.
- The admission route was set up so that patients conveyed by ambulance and those at high risk were seen and triaged immediately. High risk patients were visible from the nursing stations for observation and timely intervention. There was clear segregation for adults and children that attended the department, including separate waiting, triage and assessment areas.
- There was a secure room that was used to assess patients with mental health needs. This was not a Section 136 room (a designated place of safety) under the Mental Health Act (1983). There was a designated Section 136 room on site that was managed by an external healthcare provider and patients could be transferred to this facility if needed.
- Adequate equipment was available in all areas including appropriate equipment for children. Staff told us the equipment needed was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- Emergency bloods were stored in the hospital's pathology department and staff had 24-hour access to these if needed.
- Emergency resuscitation equipment was available in all the areas we inspected. We saw that daily and weekly equipment checklists were completed by staff. However, the resuscitation trolley checklists in the major injuries and paediatric areas had a gap where no entries were recorded to show if checks had been completed between 17 February 2016 and 20 February 2016.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines were ordered, stored and discarded safely and appropriately. Pharmacy staff were responsible for maintaining minimum stock levels and checking medication expiry dates.
- Medicines for patients to take home were readily available and stored securely. Staff told us they could contact the pharmacy if any additional medicines were needed for a patient.
- Medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures. The fridge temperature log sheet in the minor injuries area showed that between 17-22 February 2016, fridge temperatures of 9.6ºC to 10.4ºC were recorded. This exceeded the maximum

temperature range (8ºC). Staff told us the medicines kept in the fridges were frequently used which meant there was a low risk of fridge temperatures affecting the efficacy of the medicines

- There were written guidelines in place for staff to follow when fridge temperatures went out of range. This included additional monitoring of the fridges and to contact the pharmacy team or the trust's maintenance team when fridge temperatures continued to exceed the recommended temperatures. Staff told us they routinely contacted the pharmacy team and the maintenance team. However, there were no clear records to demonstrate that the pharmacy or maintenance teams had been contacted on each occasion the fridge temperatures went out of range.
- We looked at the medication charts for four patients and found these to be complete, up to date and reviewed on a regular basis.

Records

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

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 98% of all staff in the department had completed adult safeguarding level 2 training and 95% had completed children's safeguarding level 2 training. This meant the trust target of 80% completion had been achieved.
- The records also showed that 57% of nursing and medical staff had completed adult and children's safeguarding level 3 (advanced) training and the trust target of 30% compliance in this topic was achieved.
- Staff were aware of how to identify abuse and report safeguarding concerns. Policies outlined the processes for safeguarding vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified.
- Staff could also obtain support and guidance the trust wide safeguarding team or from social workers that were based on site.
- Safeguarding incidents were reviewed by the clinical matron and also by the hospital's safeguarding committee, which held meetings every three months to review safeguarding incidents and look for trends and improvements. Staff received feedback about safeguarding concerns during safety huddles and routine team meetings.

Mandatory training

- Staff received mandatory training in key topics such as infection prevention, information governance, equality and human rights, dementia awareness, fire safety, medicines management, health safety and wellbeing, safeguarding children and vulnerable adults, moving and handling, major incidents and resuscitation training.
- The overall mandatory training completion rate for staff in the emergency department was 81%. This showed the majority of staff had completed their mandatory training but the trust's internal target of 90% compliance had not been achieved.
- The failure of staff to comply with mandatory training was highlighted as a risk on the medicine division risk register. A number of actions were listed to improve training compliance, including assurances from departmental managers that staff had been scheduled for training. From March 2016 onwards, there was an action for the hospital's education department to send a monthly report showing training compliance data to divisional leads and department managers for follow up.

- Staff within the emergency department also received adult and children's resuscitation training such as advanced life support and advanced paediatric life support training.. Records showed completion rates for these were above the trust target (30%) and confirmed the majority of eligible staff had received resuscitation training.

Assessing and responding to patient risk

- An escalation policy was in place and bed management meetings took place three times per day to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- Staff also carried out 'safety huddle' meetings during handovers where specific patient needs were discussed. Staff were aware of the actions to take if a patient's condition deteriorated and were supported with medical input.
- All patients with minor injuries who presented to the emergency department themselves (self-referral) were booked in via the receptionist and then triaged by a nurse who asked routine questions using a recognised triage system to determine the nature of the ailment.
- Patients who were conveyed by an ambulance were seen immediately by a nurse via a separate entrance. We observed handovers of patients from the ambulance staff to the hospital staff. There was no dedicated ambulance triage bay but patients were placed in a treatment room so they could be assessed in a discreet manner.
- Records showed 92.6% of patients were triaged within 15 minutes between February 2015 and September 2015.
- The department failed to achieve the target for ambulance handover within 15 minutes between April 2015 and January 2016. There were 356 handovers that took between 30 and 60 minutes during this period.
- There were 122 ambulance handovers that took longer than 60 minutes (black breaches) between April 2015 and January 2016. This accounted for 11% of all 'black breaches' across the trust during this period which meant there were fewer 'black breaches' when compared with the other two urgent and emergency care departments within the trust.
- The average time to treatment was consistently worse than the 60 minute DH standard between October 2015 and February 2016.
- An appropriately qualified nurse triaged patients depending on the severity of their ailment and streamed patients to the appropriate route such as the minor or major injuries areas.
- Patients 16 years and younger had a dedicated waiting area before being triaged by a paediatric trained nurse.
- The electronic admissions system alerted staff if any patients had attended the hospital or the emergency department previously so they could be referred to specific wards if needed.
- On admission, patients at high risk were placed on care pathways to ensure they received the right level of care in a timely way.
- Staff followed guidelines and had 'care bundles' in place for the early recognition and management of patients with suspected sepsis including neutropenic sepsis.
- Staff used an early warning score system (a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. The patient records we looked at showed these checks were being carried out in a timely manner.

Nursing staffing

- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.
- The interim clinical matron had overall responsibility for the nursing and support staff within the emergency department. There was a band 7 nurse coordinator on each shift.
- The emergency department did not have sufficient numbers of nursing staff with an appropriate skill mix to ensure that patients received the right level of care. The existing establishment did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods.
- The department did not fully meet the National Institute for Health and Care Excellence (NICE) safer staffing standards for having at least one nurse for every four patients in each area and one nurse to every two patients in the resuscitation area.
- The resuscitation area had five cubicles and staffed with two nurses on each shift. The major injuries area had 11 cubicles, including a secure (mental health) room. There

were two nurses allocated to cover this area each shift. The band 7 nurse coordinator also supported the major injuries area as well as overseeing the whole department.

- The minor injuries area had six cubicles and was covered by one nurse on each shift, supported by a healthcare support worker during the early and late shifts. Patients with minor injuries were seen by emergency nurse practitioners (ENPs) between 8am and 9.30pm daily. There were five ENP's in the department with an additional two undergoing training.
- There were separate ambulance and ambulatory triage nurses in place 24 hours per day. We did not see significant numbers of ambulance patients waiting in the corridor during the announced inspection. Ambulance patients were seen by a triage nurse as part of the handover process. Following the handover, the patient was then moved to a cubicle and nursing observations were carried out by a second nurse. We observed one patient handover and saw that it took approximately eight minutes from the initial handover to when the second nurse carried out patient observations.
- During busy periods, the shift coordinator also carried out ambulance triage. If the major injuries area became full, patients conveyed by ambulance waited in the corridor. Staff told us patients with extended waits in the corridor were seen by a nurse to ensure their safety. However, there was no dedicated nurse allocated to the corridor as part of the staffing establishment. This meant that a nurse from the major injuries area would carry out this duty during busy periods.
- The department had one whole time equivalent (wte) paediatric trained nurse in post. The paediatric area had seven bays and opened between 9am and 9pm daily. Cover was provided by one nurse on both the early and late shifts (ratio of one nurse for every seven patients). When the paediatric nurse was not on duty the paediatric area was staffed with an adult nurse.
- There were vacancies for two band 6 nurse and five band 5 nurses. Recruitment for these was on-going with potential candidates at various stages of the recruitment process.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. Where agency staff were used, the trust carried out checks to ensure that they had the right level of training in delivering emergency care.
- We found the department was busy during the inspection, with most cubicles occupied and patients experiencing extended wait times. As part of the escalation process, staff from the major injuries area would be allocated to the resuscitation area during busy periods in order to maintain a ratio of one nurse to every two patients. Subsequently, staff from the minor injuries area would be allocated to the major injuries area to maintain a ratio of one nurse to every four cubicles.
- An independent review of the nursing establishment was carried out during November 2015 based on NICE safer staffing standards. The staffing review recommended an increase to the current establishment by 9.04 wte band 5 nurses, 5.53 wte band 2 support workers and the appointment of 1.4 wte band 6 ENP's in order to fully meet safe staffing standards.
- The lead nurse for the urgent care directorate told us they had reviewed the findings from the staffing review and were in the process of developing a staffing structure that would take into account the findings from the review.

Medical staffing

- Consultant cover during the week was available from 8am to 10pm on weekdays with either one or two consultants on site. At weekends one consultant was available in the department from 9am to 5pm**.** Outside of these hours, there was an on-call rota where consultants could be contacted at any time.
- There was a team of 15 junior doctors and GP trainees that worked a shift system. There were at least two middle grade doctors and four junior doctors present in the department from 8am to 2am with at least one middle grade doctor and two junior doctors between 2am and 8am. There were no specialist trainee year 4 (ST4) or grade doctors within the department.
- The emergency department did not have sufficient numbers of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- The establishment was for six consultants and seven specialty registrars. However, there were only three consultants and three registrars in post.
- The lead consultant told us they experienced difficulties in recruiting to the department and had started

international recruitment. The lead consultant told us they expected to recruit four additional specialty doctors by May 2016 as part of the international recruitment process.

- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they were subject to recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked on extended contracts so they were familiar with the department's policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the emergency department, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- Guidance for staff in the event of a major incident was available in the department and staff were aware of how to access this information when needed. This included guidelines for dealing with chemical, biological, radiological, nuclear or explosive (CBRNE) hazards and the majority of staff (78%) had received CBRNE training.
- Security guards routinely patrolled the car park; corridors and public areas in the department. Staff could call security for immediate support or contact the Police if required.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- The department conducted a major incident simulation exercise as a desktop style review annually in accordance with the regulations of the Civil Contingencies Act 2004. The most recent simulation exercise was conducted during May 2015.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

We rated this service as good for effective because:

- Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The emergency and urgent care services participated in national and local clinical audits. The services performed in line with other hospitals and performed within the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.
- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

However:

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

Evidence-based care and treatment

- Care and treatment was evidence-based and staff provided care based on the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM) guidelines.
- Staff in the emergency department used a range of care pathways, in line with national guidance, such as for fractured neck of femur, trauma, sepsis, ambulatory emergency care guidelines and recognition of stroke in the emergency room pathways.
- The emergency department participated in local and national clinical audits, such as CEM audits. Findings from clinical audits were reviewed at monthly quality and performance meetings and any changes to guidance and the impact that it would have on their practice was discussed.

- The majority of staff we spoke with told us policies and procedures reflected current guidelines and were accessible via the trust's intranet.

Pain relief

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

Nutrition and hydration

- Patients that experienced extended waiting times were routinely assessed to identify any specific nutritional requirements.
- The department had facilities to make drinks and snacks. We observed staff offering snacks and drinks to patients that had been in the department for an extended period of time.

Patient outcomes

- The department participated in national CEM audits so they could assess their practice and performance against best practice standards.
- Audits included initial management of the fitting child, cognitive impairment in older people, mental health in the emergency department and consultant sign-off.
- The consultant sign-off 2013 audit showed the level of consultant or senior doctor contact with patients was similar to or better than the national average.
- The CEM cognitive impairment in older people 2014/15 audit showed the emergency department performed similar to the England average for all the standards within the audit.
- The mental health in the emergency department 2014/15 audit showed the department performed similar to or better than the England average for most of the standards within the audit. The department performed below average for the proportion of patients for which mental state examination was taken and recorded. Staff received additional training and raised awareness of the process for referring patients to the rapid assessment interface and discharge (RAID) team for patients identified with mental health needs.
- The initial management of the fitting child 2014/15 audit showed the department performed similar to the England average for the management of children actively fitting on arrival and the recording of clinical information. The department performed worse than the average for the proportion of patients whose blood glucose was checked and recorded and the proportion of discharged patients whose parents or carers were provided with written safety information. Actions taken to improve compliance included additional training and raised awareness of the need to record blood glucose levels and the development of patient information leaflets for discharged patients.
- The department last participated in the CEM audit for severe sepsis and septic shock during 2011/12. The audit showed performance was worse than the national average for eight of the 11 indicators from the audit. This included whether vital signs were measured and recorded, high flow oxygen was initiated and evidence in the notes that first intravenous crystalloid fluid bolus was given in the department.
- We did not see any evidence to demonstrate how the department planned to improve compliance against the sepsis audit or how compliance was monitored since the 2011/12 audit. The department did not participate in the 2013/14 sepsis audit but was scheduled to participate in the 2016/17 audit that was due to commence in August 2016.
- The rate of unplanned re-attendance to the emergency department within seven days of previous attendance was above the 5% target set by the Department of Health but better than England averages (7.5% to 8%) between April 2015 and January 2016.

Competent staff

- The department had a practice educator that oversaw training processes and carried out competency assessments. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Student nurses were assigned a mentor and worked supernumerary during their first four weeks.

- Staff told us they routinely received supervision and annual appraisals. Records showed 80% of nursing staff across the department had completed their appraisals. The lead consultant told us all medical staff appraisals were up to date.
- The lead consultant also told us all eligible medical staff in the emergency department that had reached their revalidation date had been reviewed and recommended for revalidation with the General Medical Council.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the emergency department. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns. The nursing staff had good relationships with the consultants, doctors and emergency nurse practitioners.
- There were routine multidisciplinary meetings involving the nursing staff, therapists, medical staff and social workers to assess patient's needs and identify any support needed from other providers on discharge, such as home care support.
- The rapid assessment interface and discharge (RAID) team provided 24 hour support to patients with psychiatric issues and supported the staff in the emergency department. The team had specific pathways, management plans and confidential systems in place to support patients with mental health needs.
- Staff could access the hospital based social workers between 9am and 5pm during weekdays and refer to the trust-wide social worker team during out-of-hours. Alcohol liaison support was available 9am to 5pm during weekdays and patients could be referred to the service outside of these hours.
- Patients with complex mental health needs could be referred to psychiatric services or child and adolescent mental health services (CAMHS) that were available on site and provided by an external healthcare provider.
- Physiotherapy and occupational therapy support was available in the department between 9am and 9pm seven days per week and available on-call during out-of-hours.
- There was evidence of good partnership working with the regional ambulance service, with regular meetings between staff from the department and the liaison officer from the ambulance service to reduce ambulance delays.
- Staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers, mental health liaison, and alcohol liaison as well as diagnostic support such as for x-rays and scans. However, they told us they sometimes experienced delays in receiving CT scan results.

Seven-day services

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

Access to information

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

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are urgent and emergency services caring?

Good

We rated this service as good for caring because:

- Patients spoke positively about their care and treatment. They were treated with dignity and compassion. They told us staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- The CQC's accident and emergency survey 2014 showed the trust was about the same compared with other trusts for all sections, based on 241 responses received.
- Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

However:

- The NHS Friends and Family Test survey showed the department's average score was 86% between January 2015 and January 2016. This was worse than the England average (88%) during this period, indicating that a proportion of patients were less likely to recommend the department to friends and family.

Compassionate care

- Patients were treated with dignity and compassion. We observed staff providing care in a respectful manner. We saw that patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality. However, patients awaiting ambulance triage queued up in the corridor during busy periods which meant their privacy and dignity could not be fully maintained.
- We spoke with six patients. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "very clean, helpful and friendly" and "asked for a drink, was given one straight away".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between January 2015 and January 2016 showed the emergency department's average score was 86% and worse than the England average (88%) during this period, indicating that a proportion of patients would not recommend the hospital to friends and family.
- The CQC's accident and emergency survey 2014 showed the trust was about the same compared with other trusts for all sections, based on 241 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. They spoke positively about the information they received.

Emotional support

- We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- There was a relatives' room in the department that could be used by the relatives of patients that had been involved in traumatic incidents.
- Information leaflets were available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.

Urgent and emergency services

- Staff could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.
- Nursing and medical staff were included in debriefing sessions after traumatic events.

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

Requires improvement

We rated this service as requires improvement for responsive because:

- Patients attending the department experienced extended delays before they received treatment. This is in breach of regulation 12 2(a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.61% during this period.
- The total time patients spent in the department was higher than the England average between October 2015 and February 2016. There were six instances where patients had trolley waits of more than 12 hours between November 2015 and February 2016.
- There were 32 complaints relating to the emergency department between January 2015 and December 2015. However, only three of these were resolved within the trusts specified timeline of 60 days.

However:

- An urgent care improvement plan was in place to improve performance against waiting time targets and key actions were planned for completion by August 2016.
- The proportion of patients leaving the department without being seen was within the target of 5% and similar the England average between February 2015 and January 2016.
- There were systems in place to meet the needs of vulnerable patients, such as patients living with dementia or a learning disability.

Service planning and delivery to meet the needs of local people

- The emergency department provided care and treatment for patients across Bury and the surrounding areas. Records showed that 62,625 patients attended the department between November 2014 and November 2015 with an average weekly attendance of 1,204 during this period.
- 85% of patients attending the emergency department were adults with the remaining 15% were children up to16 years of age. There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.
- There was an escalation policy that provided guidance for staff when dealing with periods where there was significant demand for services. Bed management meetings took place three times per day to monitor capacity and patient flow within the department.
- The matron told us the emergency department had approximately 12,000 child attendances during the past year. This was below the 16,000 threshold set by Royal College of Paediatrics and Child Health guidelines which meant the department was not required to employ a consultant with sub-specialty training in paediatric emergency medicine.
- The paediatrics area in the department operated from 9am to 9pm daily. The hospital did not have a dedicated children's ward. Any children attending the department outside of these hours were transferred to the trust's other hospitals where these facilities were available. A nurse from the department usually accompanied patients being transferred.
- There was insufficient capacity and cubicle space to treat the number of patients arriving in the department.
- As part of the escalation plan, patients with complex needs could be placed in the major injuries area if there was no space in the resuscitation area. We saw that a patient received treatment in the major injuries area because the resuscitation area was full during the inspection. The patient received appropriate care and was transferred to a hospital ward after a short period time when a bed became available.
- As part of the escalation plan, the paediatric area was used to accommodate adult patients during busy

periods. During the inspection, we saw the paediatric area had six cubicles and these were used to accommodate both adults and children. Each cubicle had curtains for privacy but there was no proper segregation between adults and children. Royal Colleges' guidelines state there should be appropriate 'audio-visual segregation from adults'.

- A risk assessment had been carried out and control measures included ensuring a nurse presence in the area at all times, children are accompanied by a responsible adult and a doctor or nurse should be with the adult patients whilst in the paediatric area.
- As part of a permanent resolution, there were plans to modify the layout in the area by reducing the number of paediatric cubicles from six to two with a wall to segregate the reduced paediatric area. This would allow for four additional cubicles in the minor injuries area. The proposed layout changes had been approved and were planned for completion by the end of April 2016.

Meeting people's individual needs

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

Access and flow

- The Department of Health (DH) target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The emergency department consistently failed to meet this target between April 2015 and February 2016.
- The average monthly percentage of patients seen within four hours of arrival ranged between 74.35% and 97.12%, with an overall average of 84.61% of patients seen within four hours during this period.
- The department achieved the 95% target in only five weeks during this period. The five weeks where waiting time standards were achieved occurred during June and July 2015 as the department participated in a 'perfect week' exercise during June 2015 and this had a positive impact on patient flow and performance against waiting time standards.
- The average total time spent in the emergency department by admitted and non-admitted patients was higher than the England average between October 2015 and February 2016.
- The percentage of emergency admissions waiting between four and 12 hours to be admitted was similar to the England average between August 2014 and June 2015, rising above the average during July 2015 to August 2015.
- The department failed to meet the DH guidelines relating to trolley waits. There were six incidents reported where patients had trolley waits of more than 12 hours between November 2015 and February 2016. This included five breaches reported in January 2016 and one breach reported in February 2016 indicating a worsening trend. There had previously been no reported 12-hour trolley wait breaches in the department between February 2015 and December 2015.
- The proportion of patients leaving the department without being seen (2.26%) was within the DH target of 5% and similar the England average between February 2015 and January 2016.
- We observed patients in the department that self-presented or arrived via ambulance. The department was busy with a regular influx of ambulatory patients and ambulance patients awaiting treatment.
- Staff in the department were busy and attempted to manage patient flow but we saw that some patients did not receive treatment in a timely manner.
- During the unannounced inspection there had been 52 attendances between 12am and 2pm, including at least 14 patients that had exceeded the four-hour wait times. The department had issued an ambulance divert

protocol for a two hour period as they were unable to cope with the volume of ambulances arriving at the department. Ambulances were diverted to the trusts' other emergency departments to alleviate pressure.
- The patients we spoke with during the inspection told us they had experienced long waiting times, including a patient that was still in the department seven hours after arrival.
- The department reported 12-hour breaches as serious incidents and carried out root cause investigations where ambulance handover delays exceeded two hours.
- The main reason for delayed treatment and waiting time breaches was due to capacity constraints in other parts of the hospital (referred to as 'exit blocking'). This means patients could not be admitted and transferred to the wards in a timely manner.
- The urgent care improvement plan was in place to improve performance against waiting time targets. This included actions to formalise escalation processes, review staffing arrangements and implement rapid assessment and treatment (RAT) processes. Key actions listed in the improvement plan were planned for completion by August 2016.

Learning from complaints and concerns

- The emergency department had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the patient advice and liaison service. The patients we spoke with were aware of the process for raising their concerns with the trust.
- The trust's complaint policy stated that complaints would be acknowledged within three working days and resolved within 25 working days for routine complaints or within 60 days for complex complaints that required investigation or root cause analysis.
- There were 32 complaints relating to the emergency department between January 2015 and December 2015.
- Records showed 22 of these complaints had been resolved but only three of these were resolved within 60 days. The remaining 10 complaints were still being investigated. The most frequent reasons for complaints were due to a failure to treat or diagnose patients appropriately or due to delayed treatment or diagnosis.
- Information about complaints was discussed during monthly quality and performance meetings to raise staff awareness and to aid future learning.

Are urgent and emergency services well-led?

Requires improvement

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

- The emergency department did not have a documented strategy specifically for the service. The clinical director was in the process of developing a new strategy. The service delivery was based on the trust values and core objectives and staff had a clear understanding of what these involved.
- The clinical governance system allowed key risks to be escalated and these risks were monitored through monthly quality and performance meetings. However, the length of time taken to respond to these risks meant the department did not have a proactive risk management process.
- The urgent care directorate was formed recently and the clinical director and lead nurse for urgent care services across the trust had only been in post since December 2015 and January 2016 respectively. The management team understood the key risks and challenges to the service and the actions planned to address them.

However:

- There was effective local leadership and staff spoke positively about the support received from the lead consultant and clinical matron. The majority of staff were positive about the culture within the department and the level of engagement from their managers.

Vision and strategy for this service

- The trust vision was to become 'a leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.' This was underpinned by a set of values that were based on being 'quality driven', 'responsible' and 'compassionate'.
- As part of the trust's overall strategy there were six strategic goals and 10 core priorities for 2015/16 that

covered a range of areas including patient safety, improving quality and performance, clinical and financial sustainability and improving staff morale and leadership.
- The trust vision and values had been cascaded to staff across the emergency department and staff had a clear understanding of what these involved.
- The emergency department did not have a documented strategy specifically for the service. However, the service delivery was based on the trust values and key objectives and performance targets were based on the trust values and core objectives.
- The clinical director was in the process of developing a new strategy for the urgent and emergency services across the trust.

Governance, risk management and quality measurement

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

Leadership of service

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

Culture within the service

- All the staff we spoke with were highly motivated and spoke positively about the care they delivered. Staff told

us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- The medical and nursing staff worked well as a team but staff morale had been low because of staffing issues and the increased workload from the high volume of patients that attended the department.
- Sickness rates for May and December 2015 was 0.68% for medical staff and 5.38% for nursing staff. This was better than the trust target of 5% but the nursing staff sickness rates were worse than the England average during this period.
- The staff turnover rate between May and December 2015 was 18.18% for medical staff and 10.84% for nursing staff. This was much higher than the trust target of 8%.

Public engagement

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

Staff engagement

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

Innovation, improvement and sustainability

- The clinical director and lead nurse told us the key risks to the service were around staffing levels and the flow of patients out of the emergency department. They were confident the outcomes of the staffing review and urgent care improvement plan would address these risks.
- The department underwent extensive refurbishment during 2014 including a new children's emergency department. The interim matron and lead consultant were aware that the “devolution of Manchester” proposals could have an impact on services in the future. However, they were confident about sustainability of services at the hospital.

Medical care (including older people's care)

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

Information about the service

Medical care services at Fairfield General Hospital provides care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology. The hospital also offers specialist services such as clinical haematology. The hospital serves a population size of approximately 185,000 and medical services trust wide had 85,000 admissions between February 2015 and January 2016. The hospital employs 402 whole time equivalent nursing staff in medical services and has 198 medical beds.

We visited Fairfield General Hospital as part of our announced inspection on 25 February 2016 and the unannounced part of the inspection on 17 March 2016.

As part of this inspection, we visited ward 9 (general medicine and acute stroke), ward 20 (general medicine), ward 21 (general medicine), ward 1 and 2 (cardiology), the endoscopy unit, the acute medical unit, ambulatory care and the discharge lounge.

We reviewed the environment and staffing levels and looked at 31 care records and two prescription charts. We spoke with four family members, 11 patients and 27 staff of different grades, including nurses, doctors, ward managers, occupational therapists, physiotherapists, speech and language therapists, healthcare support workers and the senior managers who were responsible for medical services.

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

Medical care (including older people's care)

Summary of findings

We rated medical services at Fairfield General Hospital as requires improvement overall because:

- Clinical staff had access to information they required. However, we found standards in record keeping required improvement and records were left unsecured on the acute medical unit and ward 21.
- It was unclear if resuscitation equipment was always being checked which meant that emergency equipment might not be available when needed.
- Training levels in medicines management was low
- Staffing levels were largely adequate to meet the needs of patients but there were occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors.
- Staff were not always following trust policies and procedures in relation to assessing patients for capacity and in the completion of capacity assessments. Nursing staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint.
- We found there was insufficient bed capacity on occasions on the medical wards to meet the needs of people within the hospital but there were systems in place to ensure they were reviewed by the medical team if they were on other wards. There were a number of patients who did not stay in the same ward for the entirety of their time in hospital.
- There were governance structures in place which included a risk register. Some risk on the register had been there since 2011. It was unclear if all risks were managed in effective timely way to lower the risk. It was unclear if learning was shared wider across other service areas. There were times when complaints took a long time to resolve.

However,

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

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

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

- Records trolleys were left unlocked and records we looked at were not always documented accurately.
- Medical wards at the hospital were generally visibly clean and staff followed good hygiene practice, although we saw staff entering rooms for patients with infections not wearing protective equipment. We also observed side room doors left open and no signage on the doors to indicate that the patient had an infection.
- There was good monitoring of infections, although we did not see any evidence of actions to improve standards, however we have been told that an improvement plan was in place.
- Resuscitation equipment had tamper seals applied but on ward 21 it was unclear if the seal had been changed and the contents of the trolley checked. There was no evidence that equipment checks had been done prior to the inspection on ward 21 and records had been completed in advance. This meant there was a risk that equipment might not always be available when needed.
- Just over half of the staff required to undertake medicines management training had completed this at the time of the inspection.
- Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations at local level but there was no evidence that learning had been discussed at the main governance meeting.

However;

- There were some staff vacancies which were noted on the risk register and actions had been identified to mitigate this risk. Nurse staffing levels were overall sufficient to meet the needs of patients; however, there had been a reliance on temporary staff on the some of the wards as well as the use of locum doctors.
- There were safe systems for the handling and disposal of medicines, and checks on medication showed they were in date. Temperature checks of fridges storing medication had been completed

Staff attended mandatory training courses and compliance rates were above the trust target.

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff across the service who were all aware of how to report incidents.
- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident. For example, when a patient had fallen or when medication had been missed as a patient was off the ward for clinical investigation.
- There had been no never events reported in medical services between December 2014 and November 2015 (never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented).
- Between December 2014 and November 2015 there were 1,444 incidents reported in medical care services at the hospital. Of these, 1,350 resulted in low or no harm to patients.
- Between December 2014 and November 2015 there had been 26 serious incidents reported throughout medical services at the trust. We could not disaggregate the number for this hospital. Information showed slips, trips and falls was a commonly occurring incident followed by delay in treatment and sub-optimal care of deteriorating patients.
- A root cause analysis tool was used to investigate serious incidents, and we saw that where required an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning, which were shared with clinical teams and the wider trust through governance processes in place.
- Senior staff told us general feedback on patient safety information, including incidents, was discussed at ward staff meetings or in staff huddles. On the wards we visited, senior staff met with ward staff to look at lessons learnt from incidents.
- Grand rounds also assisted learning from incidents and staff were able to give us an example when this had happened. Grand rounds are formal meetings for doctors to discuss clinical issues and learning.

- Staff told us they received feedback from incidents from all services across the trust via an electronic lessons learnt bulletin on a monthly basis. Staff were able to describe an example of actions taken following an incident. For example, there had been an increase in training on escalating early warning observation scores and the transfer policy to ensure patients were transferred to wards safely.
- Information about incidents was discussed for medical care as part of the 'Divisional and Directorate Quality and Performance' meetings. However, on reviewing the minutes of the meeting for September, October and November 2015, it did not appear that learning was discussed although the number of incidents and outstanding action plans were.
- Mortality and morbidity meetings were held on a monthly basis. Meeting minutes showed that actions and learning were identified but it wasn't always clear who was responsible for their implementation or the timeframe that it would be expected in.
- Staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when this had been implemented. The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- Safety thermometer information for medical services across the trust showed that between November 2014 and December 2015, there had been a total of 34 CAUTI's, 59 pressure ulcers and 89 falls that resulted in harm.
- Between December 2014 and November 2015 there were 677 recorded incidents of falls at the hospital and 668 of these resulted in low or no harm.
- The service was monitoring incidents of pressure ulcers and falls through their performance dashboard each month and these were reported to the trust's quality and performance committee and the board.
- The issue of falls was recorded on the medical division risk register with actions and timescales to mitigate the risk, such as ensuring that all staff followed the trust's falls policy and completed risk assessments.
- Safety thermometer information was prominently displayed on all of the medical wards and units we visited.
- Senior staff were aware of changes in practice that had taken place as a result of a recent safety thermometer audits. This included a central store on site for staff to access equipment for patients who were at risk of a pressure ulcer.

Cleanliness, infection control and hygiene

- The wards we visited were visibly clean and free from odour; we observed cleaning of the environment whilst we were on the wards.
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- The majority of staff followed hand hygiene practice, including bare below the elbow guidance, and used personal protective equipment (PPE) where appropriate. However, on the acute medical unit we saw that one member of staff didn't use PPE when caring for a patient who was in a side room due to an infection. . In addition, there was no PPE equipment available in the ambulatory and discharge lounge areas. We raised this with staff at the time who arranged for PPE to be available for staff to use.
- As good practice the trust did not use different coloured PPE equipment, for example yellow aprons instead of white aprons, to indicate that they were providing care for patients with an infection.

- Between January 2015 and November 2015 medical services trust wide reported 28 cases of clostridium difficile infections and five cases of methicillin-resistant staphylococcus aureus (MRSA). We could not disaggregate the information for this hospital.
- Monthly infection control audits were undertaken across all wards which looked at standards such as cleaning schedules of commodes and implementation of trust policy. In October 2015 all of the medical wards were above the trust target of 88% in all standards except for the cleanliness of commodes. Only ward 2 and 11B were above the trust target for the cleaning of commodes. No actions for improvement were recorded on the information provided by the trust. However, senior staff told us that following the results new commodes had been purchased that were easier to clean.
- Monthly hand hygiene audits were undertaken through observation of staff providing care and treatment. Results were mostly around 100% across medical and care of the elderly wards. However, we looked at the results of four audits which showed wards 7, 11B and 21 were not always achieving 100%. For example in July 2015 ward 7 score was 80% and in October 2015, ward 21 scored 85% and ward 11B was 88%. No actions were recorded on the information provided by the trust which showed how they were going to improve standards.
- Monthly environmental cleaning audits were also undertaken and results were mostly within or above the target of 90%. However, in October 2015 ward 2 only achieved 70%, ward 11a 75%, ward 21 82% and ward 9 scored 85%. No actions were recorded on the information provided by the trust to show how they were going to improve standards.
- All wards had anti-bacterial gel dispensers at the entrances and near to bedside areas. Appropriate signage, regarding hand washing for staff and visitors, was on display.
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the majority of rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. However, on the acute medical unit there was no infection control signage in place for three side rooms that housed patients with infections and all the doors were left open. There were also doors left open on two side rooms for patients with an infection on ward 21. Staff told us that this was due to patients requiring observations as they were at high risk of falls, however a risk assessment had not been completed.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and completed as required. Wards were using the national colour coding scheme for hospital cleaning materials and equipment so that items were not used in multiple areas, therefore reducing the risk of cross infection.
- Trust patient led assessments of the environment (PLACE) in 2015 showed a standard of 100% in cleanliness. This score was above the England average.

Environment and equipment

- Most areas we visited were bright and well organised.
- In order to maintain the security of patients, visitors were required to use the intercom system outside the majority of wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the majority of wards we visited. However, on ward 21 there was no evidence that this had been done prior to the week of the inspection and had already been completed (in advance) for the day after the inspection. In addition, the tamper tag number remained the same for three days which suggested that the tag had not been removed to check the contents of the resuscitation trolley. This was raised with the ward manager who assured us they would investigate the issues raised. This meant there was a risk that emergency equipment may not be available when required.
- There were systems to maintain and service equipment as required. Records indicated that defibrillator equipment had been checked and hoists had been serviced regularly.

- Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date on most of the wards. However, on ward 2 there was a blood pressure machine that did not have an up to date certificate.
- Cleaning chemicals were left in an unlocked area on ward 21, although the room was lockable. These should have been stored securely as the chemicals were potentially hazardous and presented a risk to people's health.
- In the ambulatory care and discharge lounge areas, there were needles in unlocked trolleys that were accessible to patients and the public
- Trust patient led assessments of the environment (PLACE) in 2015 showed a standard of 98 % for facilities. This score was above the England average.

Medicines

- Medicines were prescribed electronically throughout the medical specialities and the care of the elderly wards.
- Between December 2014 and November 2015 there were 57 medication errors reported in medical services at the hospital. Of these 56 resulted in low or no harm. From the minutes of the meeting, Medication errors and trends did not appear to be discussed at the main divisional quality and performance meeting.
- Specific staff had been identified to undertake medicines management training and only 53% of staff in medical services at the hospital had completed this training at the time of the inspection. The trust target was 85%.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were mostly completed on the wards we visited. However, on the acute medical unit they had not been completed in January 2016 on three occasions and eight occasions in February 2016. Staff were able to tell us the system identified to reset the thermometer to check the fridge temperature range.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored securely and records indicated they were checked appropriately. Access was limited to qualified staff employed by the trust. We reviewed a sample of stock balance records for controlled drugs and found they were correct.
- Emergency medicines were available for use and records indicated that these were regularly checked. They were stored in containers with tamper-seals in place on the majority of the wards apart from the acute medical unit where the tamper-seal had been broken.
- Suitable cupboard and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. We checked a sample of medicines on the wards and found them to be in date, indicating there was good stock management systems in place.
- Patients were provided with a lockable drawer in which to store their medication, enabling them to continue to take their medication at the times they were used to taking the medication at home. This meant that patients were given a choice and steps were taken to maintain their independence.
- A pharmacist visited medical wards each week day. Pharmacy staff said they checked that the medicines patients were taking when they were admitted to the wards were correct and that records were up to date.
- There were monthly medicines management audits as part of the nursing metrics. We looked at the findings between October 2015 and January 2016 and saw that wards across the trust were scoring above 90% compliance with standards. However, the information provided by the trust did not identify any actions to improve compliance with the standards.
- We looked at two prescription records for patients and found that these were accurately and fully completed.
- The service undertook regular use of antibiotics audits which showed poor recording of the review and stop dates of antibiotics. Recommendations were identified to improve standards which included re-auditing to monitor improvements.

Records

- We observed for each patient there were up to three sets of records which were a mixture of paper based records and electronic records. This meant there may be a risk that important information may be difficult to find in an emergency.
- Medical services undertook an annual medical records audit, which included 13 standards, such as whether entries were dated and whether all pages in the record had the patient's name recorded. This years' audit showed that the service did not achieve over 95 % compliance for any of the 13 standards.

- The results showed that 85% of entries were dated however; only 10% of staff entries included the name and speciality of the clinical lead in charge of care. There were concerns that only 53% of pages in patient records had the patient name recorded. Whilst this had increased from 34% the previous year, there was a risk that important patient information may be mislaid or filed in an incorrect record. In addition, only 3% of entries made by non-registered practitioners, for example student nurses, were counter-signed by the supervising health care professional. This meant there was a risk that incomplete or incorrect information may be recorded.
- Medical services had put in place an action plan to improve standards. For example, to ensure that ward clerks inserted blank history sheets with patient identification visible on every side in patient records and to ensure that all junior doctors attend the mandatory record keeping training. Data provided by the trust showed at the time of the inspection 93% of doctors at the hospital had completed their information governance training. This training included how to meet standards required to handle care and patient information. However, there was no action recorded on the action plan to improve the number of counter-signed entries made by non-registered practitioners.
- We reviewed 31 care records as part of the inspection. Recent entries were legible, signed and dated. They were not always easy to follow but medical staff had detailed information for patient's care and treatment and all had a completed a nursing assessment and management plan.
- We looked at six of the records to see if they had been seen by a consultant within 12 hours of admission. Only two patients were recorded as being seen in the timeframe. Two records had incomplete initial assessments by medical staff.
- On ward 1 and 2 we saw there was loose-leaf papers containing patient information in two patient records we reviewed. This meant there was a risk that important information may get mislaid.
- Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- Wards had lockable patient note trolleys. On most wards, patient notes were kept away from patient and public areas. However, on the acute medical unit trolleys containing patient notes were left open and unattended in the corridors. On ward 21 patient notes were left out on the resuscitation trolley in the corridor. This increased the potential for patient confidentiality to be breached.
- The trust had begun to implement a new electronic record system to record all aspects of patient care. Staff told us that there had been problems with it and the system and was no longer being used on the medical wards until these issues were resolved.
- The majority of patient information boards that were visible in ward corridors respected patient confidentiality by patient names being covered up. However on the acute medical unit and ward 2, information was visible for patients and the public to see. Patient information boards were used to provide at a glance an overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team that provided guidance during the day, Monday to Friday. Staff had access to advice out of hours and at weekends from the hospital on-call manager.
- The trust annual report showed between April 2014 and March 2015 there were 188 adult safeguarding referrals from across all services at the hospital made to the trust safeguarding team.
- Training statistics provided by the trust showed that in medical services at the hospital all staff had completed safeguarding adults level 2 training and safeguarding children level 2 training. Specific members of staff had been identified to do safeguarding level 3 training and 82% of them in medical services across the trust had completed this training.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- Staff we spoke to had a clear understanding of the trust's safeguarding policy.
- Senior staff in medical services did not have an overall awareness of the number of safeguarding referrals that had been submitted to the safeguarding team and they did not receive any feedback from referrals made.

Medical care (including older people's care)

Mandatory training

- Staff received mandatory and statutory training on a rolling annual basis in areas such as infection control, manual handling and fire.
- At the time of our inspection, 97% of staff in medical services at the hospital had completed their required training which was above the trust's target of 85%.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition deteriorated. The MEWS system used clinical observations within set parameters to determine how unwell a patient was. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above).
- A MEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring for example every two hours.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. Repeated checks of the early warning scores were documented accurately.
- An audit of the MEWS system was completed in September 2015. The overall results were positive but further actions were put in place to improve care. This included ensuring ward rounds for patients over 85 year old , with one or more additional disorders or diseases, were undertaken regularly rather than on an ad-hoc basis.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).
- Intentional observation rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. We checked five intentional rounding records for patients on ward 21 and two were not completed accurately and it was unclear if they had been undertaken.
- The service undertook nursing metrics every month where the allocated matron visited the ward area to look at medication, documentation, observations, nutrition and infection control. The results for July 2015 to September 2015 showed that overall the results were good but there were still areas of concerns. For example how staff managed the nutritional and continence needs of patients. Actions plans were in place to improve standards.
- There was no surgical consultant cover at the hospital and if a medical patient required surgery of a surgical review by a consultant, they would have to be transferred to another hospital. There was a standard operating procedure in place for the transfer of patients but senior managers said there had been times when this had not gone smoothly. This issue was not recorded as a risk on the risk register.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust on a six monthly basis. The last audit was in November 2015. This review showed that the wards were safely staffed but noted the high level of sickness and vacancies in the service which were being covered by temporary staff.
- Matrons met each day to discuss nurse staffing levels across medical services to ensure there was good allocation of staff and skills were appropriately deployed and shared across all wards.
- At the end of November 2015 the vacancy rate for nursing staff in medical services trust wide was 7% and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme. Managers knew where there were shortfalls and where there was surplus on other wards so that staff that could be called on if needed. Vacancies were being covered by using agency or bank staff.
- We reviewed the use of agency and bank nurses between April 2014 and March 2015 which was

submitted by the trust and found that there were a number of wards which used temporary staff quite regularly. For example in March 2015 on the rehabilitation ward 45% of shifts were filled with temporary staff and ward 11A had 37% of shifts filled with temporary staff. The average number of shifts filled throughout the year on ward 8 was 15%.

- Staff on the ward 2 (cardiology) looked after patients who needed level one and level two care. They were assessing the acuity of the patients on a regular basis to determine if they were level one or level two patients. This was done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention.
- Wards allocated at least one qualified nurse and health care support workers to each bay to get to know the patients and provide a constant presence within the bay.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- The trust used the national benchmark of 80% of nursing shifts would be filled as planned during the day and night. We reviewed staffing figures for August 2015 to November 2015. All medical wards were above this benchmark during the day and night. For example the average fill rate for ward 11B was 100% during the day and 103% at night and ward 7 was 89% during the day and 98% at night.
- The service used the trust escalation procedures if there was a reduction in the number of nursing staff of duty. This included undertaking a risk assessment and escalating the issues to the chief nurse or divisional director.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing was appropriate at the time of the inspection. However, a number of concerns were raised by doctors and nurses that there was no consistency with the consultant cover on wards which impacted on continuity of care for patients.
- There was an on call rota which ensured that there was a consultant available 24 hours a day seven days a week for advice.
- The proportion of consultants working in medical services trust wide was 40% which was higher (better) than the England average of 34%. The proportion of registrars was 30% which was below (worse) the England average of 39%. The proportion of junior doctors was 23% which was higher (better) than the England average of 22%. Middle grade levels were about the same as the England average.
- The total number of medical staff vacancies at the end of November 2015 was 11.94 whole time equivalent doctors. The turnover of medical staff in medical services at the hospital between April 2014 and March 2015 was high in three specialities. In general medicine the turnover rate was 66%, in gastroenterology it was 29% and in stroke services it was 16%.
- There were still some medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme.
- Information provided by the trust at the time of the inspection showed the total number of shifts covered by locum medical staff in medical services trust wide, between April 2014 and March 2015, was variable. However, in the medical emergency unit at the hospital, the average percentage of shifts filled between January 2015 and March 2015 was 43% and in respiratory it was 22% during that time.
- This was for a number of reasons including, vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency

Major incident awareness and training

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

Are medical care services effective?

Medical care (including older people's care)

Requires improvement

We rated medical care services as 'Requires Improvement' for Effective because;

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

However;

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

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. The service were beginning to monitor compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance and further actions had been identified.
- The service participated in all of the clinical audits it was eligible for through the advancing quality programme. Where the service was not meeting the appropriate care score, targeted action plans were completed to address areas identified for improvement. For example, an action plan had been put in place to improve the results of the chronic obstructive pulmonary disease.
- Care pathways were in place for managing patients that needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The ambulatory care pathways included care of patients with cellulitis, pulmonary embolism (PE) and deep vein thrombosis (DVT). The care pathways were based on NICE guidance.
- A new falls care bundle had recently been implemented but after a recent fall concerns had been raised with managers that the staff guidance was not easy to find. Managers assured us that this was being looked into to ensure staff were fully supported when caring for patients who were at risk of falls.
- There were examples of recent local audits that had been completed on the wards. These included documentation and discharge audits. Senior staff said they received the results of the audits and any learning was shared with them via email.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us they were asked about their pain and supported to manage it.
- We saw that the level of pain patients were in was recorded on early warning scores documentation. However, if a patient was subject to neurological observations different documentation was used to record early warning scores which did not include the recording of the level of pain. Therefore, it was unclear if patients had been asked about their pain as it was not being recorded on the documentation.
- We checked seven patient records to see if their pain score was being recorded and found only three were fully completed.
- Services had recently implemented a specialised tool to assess pain in those who had a cognitive impairment

such as those living with dementia or a learning disability. However, we did not see any completed assessments in the notes we reviewed of patients who had a cognitive impairment.

Nutrition and hydration

- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken on a weekly basis across all medical wards and in December 2015 there were only 50% accurately completed across the trust. The target was 85%. Actions were in place to improve standards. For example, increasing training for staff and a ward accreditation scheme to be developed to include the focus on nutrition.
- We looked at nutritional assessments for six patients and found that only four had been fully completed. Only three of the seven fluid balance charts we reviewed in records correctly recorded the total amounts for each patient.
- A coloured tray system was in place to highlight patients that needed assistance with eating and drinking.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack for them.
- We saw there was a comprehensive selection of meals available from a menu which was available for patients.
- We observed drinks were available and in reach for all patients. Services used different coloured tops on jugs containing water for patients. This was to denote that water had been changed each morning, afternoon and evening.
- Medical staff told us that they had received competency training for the placement of nasogastric tubes (NG) for patients. They said they would document the position of the NG tube in notes. Nurses said they did not check if the doctor was competent. They did however ensure that the doctor reviewed the position of the NG tube. Nasogastric tubes are special tubes that carry food and medicine to the stomach through the nose.
- We checked one of the records for a patient who had a nasogastric tube and found that review of the position under x-ray had been done by the senior house officer and documented.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/14 for this trust showed the percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) that were seen by a cardiologist prior to discharge was about the same as the national average at 95%. However, only 17% of patients with an N-STEMI were admitted to a cardiology ward which was worse than the England average of 55%.
- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results for February 2016 rated the hospital overall as a grade 'A' which was an improvement from the previous audit results when the hospital was rated as the 'B' (with 'A' being the best score and 'E' being the lowest). This showed that patients who had had a stroke received good care at the hospital.
- However between March 2015 and July 2015 the hospital had increased mortality rates for patients admitted with acute cerebrovascular disease(stroke). The hospital had put actions in place to improve care. For example an audit of stroke mortality data and a review of all deaths from strokes for patients admitted to a non-dedicated stroke ward.
- The 2013/2014 heart failure audit showed the hospital performed worse than the England average for all four of the clinical (in hospital) indicators and better in two of the eight clinical (discharge) indicators.
- In the 2013 national diabetes inpatient audit (NaDIA) for the hospital was better than the England average in 16 of the 21 indicators.
- The endoscopy unit had been awarded Joint Advisory Group (JAG) accreditation in March 2015. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. The unit was open six days a week.
- The readmission rates for the hospital during December 2013 and November 2014 were worse than the England average in gastroenterology, but better than the England average in general medicine and respiratory medicine.

Competent staff

Medical care (including older people's care)

- Staff told us they received an annual appraisal. According to trust figures up to January 2016, 79% of nursing and other staff in medical services at the hospital had received their annual appraisal which was below the trust target of 90%. 12% of medical staff across the trust had completed their appraisal by August 2015 and 76% were on target to complete their appraisal by the target date of February 2016 although we have no evidence that this target was going to be met.
- The trust did not have a clinical supervision policy. Qualified staff told us there were no formal systems for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. However, nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- Staff confirmed that they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- There was a preceptorship programme which supported new junior nursing staff. Their competency in undertaking care procedures was assessed by qualified staff.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications.
- Staff told us that there were opportunities for development. For example to lead a shift on the ward and a volunteer had attended a dementia awareness course.
- The trust was involved in the apprenticeship nursing scheme for nursing and administrative staff with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- Medical services ensured that healthcare support workers undertook the care certificate. Nine new ward based healthcare support workers in medical services had begun this qualification. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- We saw that there was a range of specialist nurses, for example a specialist nurse for diabetes and for dementia. Staff told us they knew how to contact these specialists and felt supported by them.
- Staff said there were opportunities for development. For example to a ward manager had been supported to complete a master's degree in leadership and management.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the medical wards we visited and wards held MDT meetings which were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist. However on ward 21, these had not been held for some time.
- Staff had access to psychiatric services which provided advice and support to staff.
- Meetings about bed availability were held three times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior managers and senior clinical staff.
- Daily ward meetings, called board rounds, were being rolled out across the wards we visited. They reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. These were attended by a range of professionals.
- Ward teams had access to the full range of allied health professionals. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Physiotherapy services and occupational therapy services were available seven days a week. However, at weekends from mid-afternoon to the following morning this was by an on-call rota.
- Pharmacy services were available between 8am and 5pm Monday to Friday and between 12 noon and 9pm on a Saturday. The pharmacy was available on bank holidays and outside these hours the service was coved by an on call service. Senior staff said this was having an

impact on discharges for take home medication and there were occasions when patients had to return the next day for their medication. This was not on the directorate risk register but on the pharmacy risk register.
- Consultants were available on site 8am to 10pm Monday to Friday and 9am to 5pm at weekends. There was an on-site registrar 24 hours a day, seven days a week.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- MCA awareness training was included in safeguarding training. Information provided by the trust showed that compliance rates for this training was 100% for level 2 and 82% for level 3.
- Information provided by the trust showed that more specific MCA training was available but only 33 members of staff in medical services at the hospital had completed the training.
- Staff were not always following the key principles of the MCA when using bed rails for patients. Staff on the wards did not know that the use of bed rails can be seen as a form of restraint as outlined in the Royal College of Nursing (RCN) rights, risk and responsibilities guidance. The bed rails assessment did not specifically include the recording of consent or best interest decisions for the use of bed rails. The trust policy did state that bed rails could be seen as restraint but the recording of consent and best interest was not outlined for staff.
- Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. At the time of the inspection, there were three patients with a DoLS authorisation in place. The paperwork had been completed in line with guidance and best practice. However the formal capacity assessment that is part of the procedure had not been completed.
- Staff understanding of the application of capacity assessments to inform decisions about providing care in patient's best interest was variable. Some staff told us they would refer to social services to undertake a capacity assessment and some told us the doctor would complete these.
- The trust MCA policy outlined that 'when a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity or consent' .There was also a capacity assessment template for staff to complete contained in the policy. However, the trust DoLs policy outlined that a referral to the local authority to undertake a formal capacity assessment must be made when applying for a DoLs application. Staff appeared to be confused as to who should undertake capacity assessments which meant there was a risk that capacity assessments may not be completed for vulnerable patients. Senior staff said that whoever completed a capacity assessment would depend on the decision in question.
- We checked three records of patients who lacked capacity and found that none of them had a formal capacity assessment recorded.
- The trust safeguarding annual report showed between April 2014 and March 2015 there had been 28 DoLs applications at the hospital. Overall at trust level the number of applications was 73. This was a significant increase from the previous year when there was a trust total of 16 applications. This showed that staff had an increased awareness and understanding of DoLs.

Medical care (including older people's care)

Are medical care services caring?

Good

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

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

However,

- We saw staff interactions with people were limited on the wards we visited.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect
- We spoke 11 patients throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'staff have been very good', 'had excellent information' and 'received terrific care'. Patients said that staff always introduced themselves.
- We observed that during our time on the wards there was limited interaction between the patients and staff and patients were either in bed or sitting by their bed with no activity taking place. We did see a healthcare support worker sitting with a patient in the relaxation room on ward 21 watching a television programme but there was limited interaction with the patient.
- A patient said they felt isolated and there was limited interaction available as there was no day room on the ward and they were in a side room.
- Between November 2014 and October 2015 the friends and family test (FFT) average response rate was 44% which was the same as the England average of 44%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. The lowest response rate was ward 6 with 28% and the highest response rate was ward 18 with 78%. Over 92% of patients said they would recommend medical services at the hospital.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts for 25 of the 34 areas. These included 'patients given the choice of different types of treatment, 'always given enough privacy when being examined or treated' and 'nurses did not talk in front of them as if they were not there'. The trust fell in the bottom 20% of trusts for 'all staff asked patient what name they preferred to be called by' and 'family definitely given all information needed to help care at home'. However, this was trust-wide and could not be disaggregated specifically for Fairfield General Hospital.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE) 2015. These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey. However, this was trust-wide and could not be disaggregated specifically for medical services at Fairfield General Hospital.

Understanding and involvement of patients and those close to them

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

Emotional support

Medical care (including older people's care)

- Visiting times for the wards met the needs of the friends/ relatives we spoke to. Open visiting times were available if patients needed support from their relatives. Relatives were also able to stay overnight to be with patients who were particularly unwell.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- Chaplaincy services were available for patients and relatives if required and there was a multi-faith prayer room at the hospital. The trust also had guidance for staff on religious faith requirements which enabled staff to access to information to support patients.

Are medical care services responsive?

Requires improvement

We rated medical care services as 'Requires Improvement' for Responsive because;

- There were systems in place for the management of patients when there were shortages of beds on medical wards but at times it was unclear what patients were being reported as a medical outlier.
- There was a high number of patients who moved ward during the night and just under half of patients experienced one or more moves during their stay.
- There were occasions when people had to stay in the discharge lounge overnight and there were also high occupancy levels on the wards.
- The facilities and premises in medical care services were mostly appropriate for the services that were planned and delivered. However, ambulatory care and the discharge lounge were not altogether fit for purpose and patients who were acutely ill were being seen alongside patients waiting to go home.
- Complaints took a long time to resolve.

However,

- There was a clear focus on discharge planning with discharge co-ordinators although there were a number of patients experiencing delayed discharge because they were waiting for packages of care and could not be discharged by the hospital until funding had been agreed for this care.
- The length of stay for some patients was better than the England average.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls or vulnerable.
- There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient who had dementia
- Services took into account the needs of the local people and the trust was part of the heathier together programme. People were supported to raise a concern or a complaint.
- There was access to translation services and leaflets available for patients about the services and the care they were receiving.

Service planning and delivery to meet the needs of local people

- The hospital was part of the Greater Manchester health and social care devolution programme to provide a partnership approach to care and the healthier together programme. This was to reconfigure services across Greater Manchester into a small number of specialist centres to help meet the needs of patients
- Medical services had a designated ambulatory care unit. This unit saw patients on an outpatient basis for further tests or follow up assessments to avoid unnecessary admission or a longer stay in hospital. Referrals were from GP's and the accident and emergency department. It was open 7.30am to 8.30pm seven days a week.

Access and flow

- Between October 2015 and December 2015, April 2014 the average occupancy rate on the medical wards at the hospital was 94%. Research has shown that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Between July 2015 and October 2015, data showed there had been 173 outliers at the hospital.
- At the time of our inspection, senior staff told us there was one medical outlier. Patients who were outliers were reviewed on a daily basis by a member of the medical team. We reviewed the records for the patient

who was outlying on a surgical ward, and found they had been not been seen by the medical team as they had not been admitted as a medical patient. They were on the ward for overnight observation from A&E. Therefore, it was unclear what the service was recording as outliers for medical wards.

- In the period November 2014 to October 2015, 45% of patients experienced multiple ward moves during their stay. This was better than 49% the previous year.
- Information provided by the trust showed that between April 2015 and September 2015, the number of patients on medical wards that were transferred to another ward after 10pm at night was high for the emergency admissions unit which averaged around 126 a month. The information showing the reasons why these moves had taken place during the night was not available. Staff said that delayed discharges on the wards and beds not being identified as being available until late in the day had an impact on the number of moves at night.
- Between January 2014 and December 2014 hospital episode data (HES) showed the average length of stay for elective medicine at the hospital was 1.3 days which was shorter (better) than the England average of 3.8 days. For non-elective medicine it was 4.8 days, which was also shorter (better) than the England average of 6.8 days.
- The hospital held a bed management meeting at 10.00am each morning Monday to Friday. Bed managers supported these meetings by providing up to date information to plan bed capacity and respond to acute bed availability pressures. At the weekends, the on-call hospital manager responded to bed availability pressures.
- There was a clear focus on effective discharge planning for patients and wards. Staff discussed discharges at the daily board round and at the bed management meeting. Discharge letters were sent to GPs' and patients were given a copy.
- There was a discharge team who supported patient discharges that were complex or required rapid discharge. Discharge co-ordinators were allocated to medical wards to support the process.
- Hospital episode statistics showed that discharges at the trust were often delayed due to waiting for care packages, completion of care assessment or for equipment that was needed in the home. This was in line with similar organisations in the region. The trust were working with partner organisations to ensure that patients were discharged as soon as possible.
- To support this, the trust had access to community beds in care homes which were used for patients who were fit for discharge but were waiting for care packages or equipment to be put in place. A hospital discharge co-ordinator supported the patient and their family whilst in the community bed.
- At the time of the inspection staff said there were 26 delayed discharges across medical services at the hospital. This meant that there were 26 people in hospital that didn't need to be. These were discussed at the discharge meeting and actions put in place by the multidisciplinary team.
- Delayed discharges were identified as an area of risk in medical services and was on the risk register with actions identified to mitigate the risk. These included a discharge training package to be developed for ward teams and representation at the trust service improvement work stream looking at discharges.
- The hospital had a discharge lounge which operated between the hours of 7.30am and 8.30pm seven days a week and was split into separate areas for male and female patients. The lounge was managed by healthcare support workers who had access to nurses and doctors from the acute medical unit which was located next door.
- The discharge lounge was located in the same area as ambulatory care patients and was known as the clinical assessment discharge unit (CAD). On this unit we observed patients who were, acutely unwell, being seen by a doctor in the same area as patients who were waiting to be discharged. Although they were screened by a curtain there was limited privacy and dignity.
- Staff told us there had been times when the CAD had been used as additional inpatient beds for overnight stays and the discharge lounge area closed. Between February 2015 and January 2016 33 patients had stayed overnight.
- There had been 579 patients who had used the discharge lounge between February 2015 and January 2016.
- The suitability of a more appropriate discharge lounge was on the risk register with an action identified to carry out essential work to make an alternative ward fit for purpose. The target date for completion was March

2016. Senior staff told us that this was on the trust estate strategy but when we requested a copy of the strategy we were told this was not available as it was only in draft form.

- As part of the unannounced inspection medical staff told us that they were not aware of any plans for the discharge lounge to be relocated.
- Staff told us that there had been occasions when 16-18 year old patients had been admitted to the acute medical unit due to insufficient beds on more appropriate wards. A safeguarding referral was submitted to the safeguarding team each time this happened. Between February 2015 and January 2016 there had been 151 patients aged 16-18 admitted.
- Between November 2014 and October 2015 performance against national referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above the national average and the trust target of above 92%. General medicine and geriatric medicine were 100% compliant with the 18 week RTT.
- The above figures have been provided by the trust at the time of the inspection; however we have subsequently learnt these may be unreliable and are therefore not assured that performance is at this level. We are now working with trust to validate this information and follow up any actions arising
- Medical wards had been included in the initiative looking at the perfect week for patients during June and July 2015. This is an approach for trusts to look at challenges in meeting standards. This included ensuring that patients had a senior review before 10am, to achieve 50% of discharges earlier in the day and increase the number of discharges from the medical assessment unit to improve the flow of patients. Medical wards at the hospital did not meet three of the seven standards; however, actions were in place to improve the flow of patients through the hospital such as improving communication between discharge teams and ward staff.

Meeting people's individual needs

- The trust used a leaf symbol to indicate that a patient was frail or elderly and a butterfly symbol to indicate that a patient was subject to end of life care. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- The hospital had implemented the 'forget-me-not' scheme. This was a discreet flower symbol used as a visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- There was a specialist nurse, who was the clinical lead for dementia, who provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed patients with a cognitive impairment.
- A new flagging system for people living with cognitive impairment (including dementia) began in October 2015 as part of the electronic patient record. When a patient scored below seven on the mental test an alert was automatically sent to the safeguarding team.
- All the wards we visited had dementia friendly signage on bays and bedrooms, paintwork and flooring. Toilet and shower areas were clearly signed and toilet seats were in a contrasting colour. There were memory boxes available for staff to use with patients
- Ward 21 had adapted a room to be a dementia friendly environment with relaxing chairs and colours.
- Medical services had access to a number of IT systems which had specific programmes to support people living with dementia. For example music and events from days gone by.
- The trust used the 'this is me' documentation with people living with dementia and we saw completed ones on the wards we visited. This is a simple tool that is used to tell staff what a patient likes or does not like whilst in hospital.
- The service has a dementia strategy covering three years from 2015 to 2018. It included key objectives such as early diagnosis and improved quality of care. It outlined how the objectives would be met and measured.
- People living with a learning disability were supported when having a cardiac procedure. Staff told us how they made reasonable adjustments such as visits to the ward area and theatre before their appointment and relatives staying with them until they went to theatre. They could accommodate family staying with people who have a learning disability.
- For people who had suffered a stroke, therapy staff ran group sessions for patients, for example 'expression through drawing' group.

Medical care (including older people's care)

- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- Care plans we saw were not always person-centred to identify individual needs but did contain the necessary information to ensure that patients were not at risk.
- We saw that people had access to call bells and staff responded promptly.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas. Notice boards within the clinical areas included information about the number of complaints and any comments for improvement.
- The trust recorded complaints electronically on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.
- Information provided by the service showed that there had been 56 complaints raised across medical services at the hospital between December 2014 and December 2015. The highest number of complaints was regarding clinical treatment. On average it took 144 days to resolve the complaint. However, seven complaints took over 200 days to resolve and one complaint took over 300 days to resolve.
- An example of learning from a complaint was to ensure staff were documenting conversations with patients and family and to be aware of the impact on people when speaking with them.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers discussed information about complaints during staff meetings to facilitate learning.

Are medical care services well-led?

Good

We rated medical services as 'Good' for Well-Led because:

- Medical care services were generally well led with evidence of effective communication within staff teams. The visibility of senior management was good and there were information boards to highlight each ward's performance displayed on each ward area. There was no specific strategy for medical services but there was full engagement in the trust overall strategy and plans.
- Staff felt supported and able to speak up if they had concerns and the number of staff who felt valued was higher than the England average. Medical services captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative.
- There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

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

Vision and strategy for this service

- The trust's vision was to be a leading provider of joined up healthcare that would support every person who needed services, whether in be in or out of hospital to achieve their fullest health potential. The values were to be quality driven, responsible and compassionate. Staff were aware of the vision and values and they were displayed on the notice boards.
- The Trust's strategic objectives were based on the vision and these objectives cascaded down to service and individual objectives for staff.

Medical care (including older people's care)

- The trust had a service development strategy for 2015-2020 which included medical services. This outlined plans for the next five years which linked to the healthier together programme.
- There was no specific strategy or business plan for medical services but they contributed to the trust strategy and development plans to improve services.
- NHS staff survey results for 2015 showed that 76% of staff in medical services trust wide said they had clear planned objectives. This was about the same as the trust average of 80%. The number of responses was 250.

Governance, risk management and quality measurement

- The medical risk register highlighted risks across all medical services at the trust and actions were in place to address concerns, for example lack of staff and slips, trips and falls by patients and visitors. Each action had target date for completion of the action. However, from the information provided by the trust it was not clear if there was a review date for each risk and some risks had been on the risk register since 2011. This meant it was not clear whether all risks were being managed as effectively as possible.
- Each hospital medical directorate had an additional risk register. The directorate risk register for medical services at the hospital was relatively new and risks highlighted had only been on the risk register since January 2016. However some of the risks had the identified date as March 2016, which was after the inspection date when the risk register was shown to us. This meant it was not clear when risks had first been identified.
- Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services. The divisional quality and performance meeting for medical services was held on a monthly basis. As part of the meeting, there was a review of items to celebrate good practice and items of concern.
- It was clear from the minutes we reviewed that risks, incidents and complaints were reviewed and discussed. However, there was limited evidence how learning that had taken place was shared with staff apart from learning from complaints. Actions from the meeting were identified in the minutes along with the person responsible but not always the target date for the actions to be completed. It was therefore difficult to track what progress had been made against agreed actions.
- On a quarterly basis the division held confirm and challenge meetings to discuss performance such as serious incidents, staffing and service developments. From the minutes we reviewed key themes were identified and actions, however, it was not clear how these actions were going to be monitored. This meant it was unclear how improvements were going to be made.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance reports were used to display current information about the staffing levels and risk factors for the ward.
- There was a ward accreditation scheme in place which looked at ward performance, for example patients feel satisfied with their care and all patients have a pain assessment recorded. Ward are audited then given an award ranging from white for inadequate to gold for outstanding. All the medical wards at Fairfield hospital achieved either a bronze or sliver award. We observed that where wards needed to improve action plans had been put in place.

Leadership of service

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

Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said morale was good.
- In the 2015 staff survey, 94% of staff in medical services trust wide said they were enthusiastic about their job and 87% looked forward to going to work. This was better than the England average of 57%. 87% of staff said that medical services acted fairly with regard to career progression, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Medical care (including older people's care)

- The latest staff friends and family test results for January 2016, show that 70% of staff would recommend the hospital as a place to be treated. 57% of staff would recommend the hospital as a place to work.

Public engagement

- The trust carried out their own inpatient satisfaction survey around food at the hospital. This included medical wards. Questions included being able to choose their own meal and any problems with their food during their stay. From the results we reviewed, in October 2015, the hospital was meeting the overall performance indicator of 98%.
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. At the time of the inspection, 95% of patients would recommend the wards at the hospital to friends or a relative.
- There were comments boxes on the ward for patients and public to leave comments and suggestions. On each ward there was a 'you said, we did' board which highlighted changes that had been made following comments.

Staff engagement

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

Innovation, improvement and sustainability

- An analysis of the 2015 NHS staff survey results showed 86% of staff in medical services trust-wide, who responded, felt they were able to make suggestions to improve the work of their team/department. This was better than the national average of 74%.
- The survey also showed that 86% of staff said they had frequent opportunities to show initiative in their role. 66% of staff said they were involved in deciding on changes to improve services for patients. This was worse than the trust average of 71% but better than the England average of 51%.
- Medical services were planning to have pharmacy technicians permanently based on the wards to undertake medication rounds. This aimed to reduce the number of medication errors and more robust medication audits.
- Consultants saw patients who had diabetes in the community as part of the integrated diabetic services. They had access to electronic systems which enabled them to directly upload patient management plans for GP's to access.
- Cardiology services held nurse-led pre-op clinics and nurse dedicated consent for certain procedures such as angiograms. This improved the flow through clinics for patients and was a development opportunity for staff.

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

Information about the service

Surgical services are provided under the surgery and anaesthesia clinical group across four sites by Pennine Acute Hospitals NHS trust. Fairfield general hospital carries out a range of surgical services including orthopaedics, ear, nose and throat, urology, gynaecology, oral and dental and general surgery. Hospital episode statistics data showed 9,800 procedures were completed in the year July 2014 to June 2015; of which 10% were emergency surgical procedures, 66% were day surgery cases and 24% were elective surgery procedures.

As part of the inspection, we inspected the seven main theatres, Ward 5 (trauma and orthopaedics), Ward 12 (day surgery), Ward 14 (ear, nose and throat and general surgery). We spoke with 4 patients and looked at 15 patient care records. We spoke with 14 staff of different grades including nurses, doctors, allied health professionals, domestics, support workers, surgeons, administrators and matrons. We received comments from our listening events and from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed performance and assessed information about the surgery services. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Summary of findings

We rated surgery at Fairfield General Hospital as requires improvement overall because;

- The early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalation of concerns for a deteriorating patient were not embedded.
- The division did not always record and dispose of controlled drugs in line with policy.
- An emergency trolley was padlocked in theatres, which could prevent quick access to it in an emergency.
- We found that in four out of ten records that we checked that the doctors' handwriting was illegible on surgery consent forms.
- There was no surgical consultant on duty at Fairfield to see medical patients who required a specialist surgical consultation.
- There were difficulties recruiting surgical doctors. There was a reliance on locum doctors. There were high rate of sickness and vacancies were difficult to fill. This had at times resulted in a delay in surgical procedures being undertaken as senior surgeons were undertaking routine ward duties. They were non-compliant with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients. They also failed to comply with recommendations of the British Orthopaedic Association standards for Trauma (BOAST) standards as patients (none

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emergency) waited longer than the recommended 72 hours before seeing an orthopaedic specialist and waited longer than the recommended 36 hours when requiring surgery for a fractured neck of femur.
- The division had very high readmission rates, which were significantly higher (worse) than the England average.
- They were compliant with some but not all the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Theatre utilisation was 69.2%.
- Staff felt uncertain about the future of the Fairfield site and as such were unsure about their own prospects.

However, we also found that;

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

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Are surgery services safe?

Requires improvement

We rated safe as requires improvement because;

- We found that the early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalate concerns for a deteriorating patient were not embedded.
- The division did not always record and dispose of controlled drugs in line with policy.
- An emergency trolley was padlocked in theatres, which would prevent quick access to it in an emergency.
- We found that in four out of ten records that we checked that the doctors' handwriting was illegible on surgery consent forms.
- We identified some issues with surgical doctor's staffing, there was a high rate of sickness and vacancies were difficult to fill. This resulted in periods where senior surgeons had to delay their procedures to cover routine ward duties.
- We found surgery was only partially compliant with the World Health Organisation (WHO) checklist and National Patient Safety Agency (NPSA) 'five step to safer surgery' operating procedures.
- There was no surgical consultant on duty at Fairfield to see medical patients who required a specialist surgical consultation.

However, we also found;

- There was a good culture of reporting incidents and safety issues.
- The investigations of incidents was thorough, we saw evidence of learning when things went wrong and following incidents.
- We saw implementation of measures to improve quality and safety.
- We found that staff had the appropriate skills and training to enable them to keep people safe. They had good levels of safeguarding and mandatory training.
- The environment was clean and hygienic with low levels of healthcare associated infections.
- The division was familiar with and used the duty of candour appropriately.

Please note, the guidance text and signposts below are to be used alongside the KLOEs and associated prompts.

Incidents

- There was one 'never event' for the period December 2014 to December 2015. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The never event involved the placing of a wrong sided component during a joint replacement in trauma and orthopaedic surgery.
- The anaesthesia and surgical division at Fairfield reported over 200 incidents in the year December 2014 to November 2015. The majority of these resulted in no harm, low harm or were 'near misses'. 12 incidents were recorded as having caused moderate to severe harm to a patient and involved falls, medication errors, equipment issues, delays in diagnosis and treatment, patients' development of Clostridium difficile (Cdiff) pulmonary embolism, deep vein thrombosis (DVT) and pressure ulcers.
- Three serious untoward incidents were reported by the surgery and anaesthesia division at Fairfield in the last three months. These were reported via the STEIS system appropriately.
- We found that the surgery and anaesthesia division conducted appropriate investigations into such incidents using a 'root cause analysis' style of investigation. We found that these were conducted by appropriately experienced and skilled staff at a senior level. We also found that the results of these investigation and areas to improve safety and learned were shared with staff of all levels. This was done through newsletters, team briefings and safety huddles, notice boards displays and emails. We saw examples of practical changes and learning in response to such incidents. Incidents were also discussed in the 'pride in safety' newsletters.
- Representatives from the surgery and anaesthesia division investigated and discussed deaths and poor surgical outcomes at their regular mortality and morbidity meetings. Areas for improvement and learning were highlighted and recommendations for changes to practice were made, which were circulated appropriately to improve performance.
- The surgery and anaesthesia division were familiar with the 'Duty of Candour' procedures and processes. The

'Duty of Candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We saw examples of the 'duty of candour' being implemented appropriately following safety incidents involving patients. We found the process was in line with trust policy and national guidance. Patients and relatives were involved in the process and were offered the chance to speak with senior staff.

Safety thermometer

- The NHS Safety Thermometer is an assessment tool, which measures a snapshot of harms which may have occurred during the month (such as falls, pressure ulcers, bloods clots, and catheter related urinary infections).
- During our visit we found that safety thermometer information was displayed on entrance to each ward and was visible to patients and visitors entering the ward.
- Each ward used the results of the safety thermometer to plan areas of focus for quality improvements. It was also used to benchmark against each ward and departments.
- The trust's December 2015 'Integrated Performance Report' confirmed that the highest priority trust wide harms were pressure ulcers and falls. A pressure ulcer reduction action plan was in place within the surgery and anaesthesia division at Fairfield and they focussed on falls reduction through their participation in the trust safety programme.
- Information provided to Health and Social Care Information Centre showed that from January to December 2015 the trust reported 94.46% harm free care, this is better than the England average of 94.14%.

Cleanliness, infection control and hygiene

- Infection control policies and procedures were available and accessible to staff and the staff we spoke with were familiar with those policies and where to seek advice if they needed to.
- During our visit, we found the environment to be visibly clean and hygienic; we saw that there were effective cleaning regimes in place and that they were audited monthly.
- We observed staff following hand hygiene procedures and using appropriate protective personal equipment (PPE), such as gloves and aprons, when delivering care.
- We observed theatre staff to follow appropriate infection control protocols and gowning procedures were adhered to in theatre areas.
- Staff followed 'bare below the elbow' and uniform guidance and followed Trust policy.
- Clinical areas were free from clutter and items were appropriately stored. Wards had been through the trusts 'well organised ward' (WOW) programme, which streamlined wards and freed up space by removing unnecessary items.
- Trust audit data showed that Fairfield surgery and anaesthesia division attained no less than 98% compliance in infection control audits from July 2015 to January 2016.
- The Trust as a whole had six cases of MRSA infection, 59 cases of Clostridium difficile infection from February 2015 to January 2016. The trust were not able to advise which specific areas they related to.
- The surgery and anaesthesia division at Fairfield did not report their surgical site infection (SSI) rates. They reported the statistics through the other trust hospitals at Royal Oldham hospital and North Manchester hospital.

Environment and equipment

- Equipment such as commodes and hoists were seen to be clean and well maintained.
- The division used Electro-biomedical Engineering (EBME) to maintain and check all their equipment. Stickers were in place to show checks were up to date.
- Waste and clinical specimens were handled and disposed of appropriately, this included safe sorting, storage, labelling and handling.
- The trust used single-use, sterile instruments where appropriate and those we checked were within their expiry dates. The service had arrangements for the in house sterilisation of reusable surgical instruments.
- Staff in the theatres stated they always had access to the instruments and equipment they required and confirmed if any equipment was faulty that it was repaired or replaced promptly. There was sufficient storage space in the theatres and items such as surgical procedure packs were appropriately stored in a tidy and well organised manner.

- Bariatric equipment was available to the wards and theatres from central storage if required.
- The waiting rooms for patients in the day surgery admissions area were appropriate; they were clean, tidy, equipped with a television and comfortable seating.
- We found that emergency trolleys on surgical wards were available and accessible, were checked and maintained in line with trust procedures. However, we found that an arrest trolley in theatres was padlocked and they key was kept with the medicine key holder. This was not best practice and could result in a delay in emergency treatment while the keys were located.

Medicines

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

Records

- Nursing and medical information was available electronically and though paper records. As part of our inspection, we reviewed the records of 10 patients and we found most of these to be accurate, complete, legible and up to date. However four signed patient consent forms contained a description of side effects that was not legible. This is not in keeping with best practice and trust policy.
- The records contained the relevant patient history, patient allergy status, relevant information and applicable risk assessments. We saw care plans and pathways were completed thoroughly in nursing notes and these were completed before, during and after surgery.
- We saw that there was a good system for pre-operative assessment, which followed an effective process to assess and highlight individual patient needs. Integrated care pathways were commenced at pre-operative clinic for certain procedures.
- Patients' records were stored in lockable trolleys, which kept their personal information safe.

Safeguarding

- The surgical and anaesthesia division was 99% compliance with mandatory safeguarding training.
- Staff were aware of their responsibilities regarding safeguarding and were familiar with the process to follow; they could describe how to access the policy on the trust intranet and who to speak to for advice.
- Staff received training and annual updates, the level of training depended on their role and grade.
- Surgical staff had access to the hospital specialist safeguarding nurses who were available advice and information, outside of core hours, the hospital coordinator or matron bleep holder was available for advice.
- There was evidence that the procedures were being followed and that multidisciplinary team meeting were held to discuss the best interests and safety of patients.

Mandatory training

- Staff received mandatory training in areas such as basic life support, moving and handling, fire safety, health and safety, equality and diversity, information governance and infection control. This was updated annually by attendance on training courses or by training done remotely on a computer.
- Compliance with mandatory training and updates was 98.5% for the surgery and anaesthesia division at Fairfield.

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Assessing and responding to patient risk

- The surgery and analgesia division used an early warning score (EWS) system to identify patients at risk of deterioration. However, the document they used to record observations and scores was a traditional observation form. There was no colour coding system which clearly dictated immediate action; it was necessary that the form be cross referenced with a trust algorithm to determine trigger scores and subsequent action. When asked staff could not articulate the specific trigger scores and their appropriate response other than if a patient scored three or above then a doctor would be called. It was not clear that if a patient scored eight, that they would be treated any more urgently than if they scored a three. This uncertainty was supported by the division's own monthly EWS audit data which showed inconsistency and non-compliance with escalation procedures and correct regularity of observations.
- During our inspection, we observed theatre teams undertaking the National Patient Safety Agency's (NPSA) 'five steps to safer surgery' procedures and the World Health Organisation (WHO) checklist. Staff completed safety checks before, during and after surgery and demonstrated an understanding of these safer surgery guidelines.
- NPSA steps and the WHO checklist data were audited monthly and records of compliance were kept. Data from January to December 2015 showed 95.1% compliance with WHO briefings, however for six out of the last seven months Fairfield theatres failed to meet the trust target of 95%. The average compliance from June to December 2015 was 93%; the lowest compliance rate was for December 2015 where compliance was 91.7%, that is almost one in 10 patients had a partial safety briefing completed for their operation.
- Patients were assessed for their risk prior to surgery through assessment of patient risk factors for surgery, which is in keeping with best practice recommendations by the Royal College of Surgeons. This was done through assessing comorbid conditions, past medical history and lifestyle issues along with tests and examinations. This was assessed at pre-operative assessment clinics where possible and upon admission for emergency or other cases.
- There was no outreach team at Fairfield, deteriorating patients were referred to the ward doctor and this was escalated to emergency bleep holders. During the night this responsibility was passed to nurse practitioners. The Greater Manchester Critical Care Network (GMCCN) in a peer review report from April 2015 identified the lack of an outreach team at Fairfield Hospital as a risk to patient care. We were advised that there were plans to introduce limited critical care outreach cover later in 2016.
- The hospital had a small critical care ward, which accepted deteriorating surgical patients and those who needed extra support following surgery.
- Acutely sick patients from around the hospital, including medical patients were occasionally cared for in the recovery area in theatres. This was if no bed available in the critical care areas and was compliant with trust policy.
- A 24 hour telephone number was provided to patients upon discharge from the wards, this gave advice on what to do and who to contact if patients or relatives were concerned following discharge.

Nursing staffing

- The number of staff required for each ward was determined by the use of the 'Safer Care Nursing Tool' (SCNT) which is a recognised nursing acuity tool and is endorsed by the National Institute for Health and Care Excellence (NICE). This was audited every six months and was last completed in November 2015.
- During our visit, the wards had sufficient numbers of trained nurses and support staff on duty with an appropriate mix of skills to ensure that a safe level of care was provided to patients. Staffing figures for November to January 2016 showed that surgical wards had a minimum of 95% of their allocated establishment of registered nurses on duty in January 2016.
- Registered nursing vacancies for surgical specialities at Fairfield were 3.6% in December 2015. We were advised that the majority of vacancies had been recruited to, but staff had not started yet. Vacancies for other clinical staff which included care workers was 2.9%.
- Sickness rates for registered nurses in surgical specialities was 6.9%, for other clinical staff which included care workers was 14.2%.

- Any gaps in the rota were filled with hospital bank shifts and external agency staff. There was moderate use of agency staff which had improved over recent months. The trust were unable to supply specific figures for surgery at Fairfield.
- The division followed a safe staffing escalation process if staffing levels altered, or if the care needs of patients changed.
- The planned and actual staffing levels for the day's shifts were displayed on notice boards in each area we inspected.
- Agency and bank staff received an induction and orientation to the area they were working.
- Nursing staff handovers occurred during shift changes, and included discussions about patient needs, safety concerns and staff allocation.
- Theatres were staffed greater than Association for Perioperative Practice (AfPP) minimum staffing standards.

Surgical staffing

- Surgical wards had a daily consultant led ward round including weekends.
- Consultants were accessible by telephone for advice and support when not physically on site, such as evenings and weekends and operated a rotational on call system for out of hours periods.
- There was no surgical consultant for medical patients who required a specialist surgical consultation, they had to be transferred to another site or a consultant had to travel to the hospital from elsewhere. There was a standard operating procedure for this but we were told this was not always straightforward, and we have seen incident reports which outline delays in transfer which may have contributed to poor outcomes for patients.
- Daily medical handovers took place during shift changes. These included discussions about specific patient needs and highlighted the sickest patients and those with potential for deterioration.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required, such staff were provided with local inductions to ensure they understood the hospital's policies and procedures.
- There was a high reliance on locum doctors within the division; however most were on long term assignments with the trust.
- Some staff told us that there were instances of no ward doctor being available for routine tasks and review of patients in February 2016, this was supported by incident reports for that period and has been confirmed as an issue by the trust. The trust stated that this had been caused by difficulties recruiting permanent doctors and the long-term locum doctor leaving the trust. This caused delays in theatre list start times as surgeons had to cover routine ward duties.
- Trust data shows they have vacancies for 2.4 doctors in the surgery and anaesthesia division, this 5.8% of the total doctors staffing. The sickness rate for doctors was 4.4% which was higher (worse) than England average rates.

Major incident awareness and training

- There was a documented 'major incident plan for the Fairfield hospital site', a 'service continuity policy and strategy' and a 'crisis management plan' for dealing with major incidents and emergencies such as terrorist threats, flood, fire or process management failures.
- The anaesthesia and surgery division had a designated function as part of their role into the hospitals major incident plan.
- All staff received emergency training on their corporate induction training days.
- Managers had attended major incident 'silver control' training, which included desk top exercises and mock scenarios.
- Fire and bomb training was updated annually as part of the mandatory training package.
- Emergency evacuation tests were conducted periodically on site.
- Protocols for were in place to defer elective surgical activity to prioritise unscheduled emergency procedures in the event of a major incident.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because;

- The service was non-compliant with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- The division failed to comply with recommendations of the British Orthopaedic Association standards for

Trauma (BOAST) standards as patients waited longer than 36 hours for their operation for fractured neck of femur and longer than 72 hours before seeing an orthopaedic specialist.
- The division had very high readmission rates, which were significantly higher (worse) than the England average.
- They were compliant with some but not all the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Theatre utilisation was 69.2%.
- The readmission rates for the division were higher than the England average.

However;

- Care was otherwise planned and delivered in line with evidence based guidance and best practice.
- Patient outcomes were good and in some areas the division performed better than other trusts and England averages.
- Staff were experienced, well trained and competent in their roles.

The multidisciplinary team working was good with satisfactory access to a range of specialities.
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Evidence-based care and treatment

- The surgery and anaesthesia division used national guidance and best practice in their care and treat of patients. They monitored their own compliance against National Institute for Health and Care Excellence (NICE) standards.
- Emergency and unplanned surgery was undertaken in accordance with the national confidential enquiries into patient outcome and death (NCEPOD) and the 'standards for emergency care' recommendations by the Royal College of Surgeons (RCS).
- Care pathways followed relevant guidance including hip fracture, surgical site infection, and VTE best practice.
- The division followed NICE CG50 guidance but there appeared to be some inconsistencies in their application of the early warning system.
- There was non-compliance with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients. In particular there was no outreach service and no co-ordinated monitoring of patients who had stepped down from high dependency or critical care.
- Some staff expressed concerns that the division did not always meet the recommendations of the Royal College of Surgeons (RCS) recommendations British Orthopaedic Association 'standards for trauma' (BOAST) which advise that surgery be undertaken within 36 hours of presentation for fractured neck of femur patients. Such delays are associated with increased risks and poorer outcomes for patients. The division at Fairfield did not produce statistics on compliance with this BOAST standard as these were calculated under the trust's partner sites, which showed failure to meet recommendations in 30-40% of their patients. As Fairfield admitted patients via their accident and emergency department with fractured neck of femur and undertook operations on such patients, we have determined that Fairfield surgery and analgesia division were also non-compliant with the BOAST recommendations. Incident reports were obtained which outlined delays in operations for fractured neck of femur patients at Fairfield. Evidence suggests that this non-compliance had been highlighted several times over the last year and has been discussed at quality and governance meetings, however no improvement has been seen, nor were we able to obtain an action plan of how the situation might be improved.
- Staff also expressed concerns that there were delays in patients receiving their operations on upper limb fractures, which increased the risk of complications during surgery and poorer outcomes following surgery. They told us and evidence supports that this was due to delays in patients being seen and listed for theatre by orthopaedic surgeons and delays at fracture clinics themselves. The British Orthopaedic Association standards for Trauma (BOAST) standards recommend that Patients who presented at A&E with suspected upper limb fractures should see an orthopaedic consultant in fracture clinic within 72 hours. However, evidence indicates that between March 2015 and February 2016 34.9% of patients with suspected upper limb fractures were not seen within 72 hours. This was also supported by complaints from patients regarding

delays in the fracture clinic and by incident reports by staff regarding detailing cancellations and delays due to insufficient doctors and overbooking (too many patients put on the list).
- Enhanced recovery pathways were used in a some orthopaedic surgical procedures. Enhanced recovery is an evidence-based approach to care that helps people recover more quickly after having major surgery. This had reduced the length of stay for patients and has resulted in much shorter stays in hospital than the England average for these patients.
- The division undertook local audit activity this included areas such as record keeping audits, anaesthetic record keeping audits, EWS audits, infection control and treatment audits.
- Staff told us policies and procedures reflected current best practice guidance and available electronically on the trust's intranet. We reviewed a selection of policies which were up to date and consistent with national guidelines.

Pain relief

- The hospital has a dedicated specialist pain team which operated Monday to Friday during core times. Outside of this period advice and input was available from the on call anaesthetist.
- However, the division was compliant with some but not all the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015). Areas they were non-compliant included, they did not have full multidisciplinary representation on pain groups and did not have dedicated pain pharmacist input. The lead consultants did not have the specified advanced pain training, but did have good expertise in field. There was only limited access to pain specialists outside of core hours and the pain team did not have the full complement of staff. Pain training was available but was not mandatory as recommended.
- Patients were assessed at pre-operative clinic for issues relating to pain and their preferred method of pain relief. Potential issues or concerns were highlighted before the patient attended for their procedure.
- Staff used pain scores to assess and monitor pain as part of the patients' regular observations.
- Patients said they received pain relief medication when they needed it.

Nutrition and hydration

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

Patient outcomes

- Hospital episode statistics data showed 9,800 procedures were completed in the year July 2014 to Jun 2015; of which 10% were emergency surgical procedures, 66% were day surgery cases and 24% were elective surgery procedures.
- The emergency laparotomy audit showed that less than 50% of patients had a consultant surgical review within 12 hours of admission and less than 50% of applicable patients were reviewed by an older person specialist doctor following surgery. However, other performance indicators were good.
- The national bowel cancer audit showed the trust was slightly worse than the England average for most measures in the audit such as length of stay above five days (78.3 compared to 69.1%); the number of patients

for whom major surgery was carried out as urgent or emergency (18% compared with 15.5%); patients seen by specialist nurse (35.5% compared to 87.8%). However, it performed better for the number of patients for whom laparoscopic surgery was attempted (61.8% compared with 54.8%).

- Performance reported outcomes measures (PROMs) data between April 2015 to September 2015 showed the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was similar to or better than the England average.
- The standardised relative readmission risk for surgical patients at Fairfield was similar to the England overall for all surgeries. However, it was much higher for elective and non-elective general surgery and elective trauma and orthopaedic surgery. The division was cited on these issues and were trying to understand the reasons for this by gathering information and detail, however, did not have a strategy or plan of action in place at the time of inspection.
- The division followed showed an inconsistent response to RCS standards for unscheduled care and the British Orthopaedic Association standards for Trauma (BOAST) standards. There were sometimes delays in patients receiving emergency surgery. See the section above on evidence based care and treatment.
- Theatre utilisation was 69.2%; this does not indicate optimum use of theatre time and resources and could be improved with more effective scheduling of procedures, thus providing a more responsive and effective service to patients.

Competent staff

- New staff undertook trust inductions and completed a period of supernumerary status where their competency was assessed before they were able to work unsupervised.
- Appraisals were conducted annually with managers to review performance and feedback development issues with individual staff. Appraisals in theatres were 84% up to date, on ward 12 (day surgery) 100% and ward 14 (ENT and general surgery) was 100%.
- Staff we spoke with said their appraisals were up to date and managers said that the current long term sickness levels have had a negative impact on compliance figures.
- Doctors in the division undergo their appraisals as part of their revalidation process, the trust have established a robust system for ensuring this is effective and have a 100% appraisal and revalidation record.
- Doctors stated they could discuss issues with their managers and felt supported in their development and training. Although they stated there was not a formalised system of clinical supervision, it was done on an ad hoc basis. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work.
- The junior doctors we spoke with told us that the work they were doing was interesting and challenging and gave them the opportunity to develop their surgical skills and experience in a supportive environment.
- The trust had procured a tailor made computer programme to assist nurses with their revalidation procedures; this assisted them with the completion and compilation of the required document. Wards had recorded the dates that revalidation was required, so as to help manage the process for staff.
- Nurses though told us that they had regular meetings with their manager and they were able to speak to their manager at any time.
- Staff told us there were opportunities for learning and development and felt they were given the right amount of support by mentors and senior staff.
- Many staff had many years of experience in the surgical specialities and appeared competent, enthusiastic and dedicated to their work.
- Senior staff led by example and provided support and mentorship to junior staff.
- The trust had entered the new care certificate scheme for non-registered care and support staff, but only a few individuals had completed this at the time of our visit. This was seen as a positive step by most staff.

Multidisciplinary working

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

needs were better accommodated on a different site or there was theatre space elsewhere which ensured prompt surgical treatment, a patient could be transferred.
- Team working between the various disciplines was good and the team spirit was positive. They worked seamlessly together to provide holistic care.
- On the wards there was a joined up approach to patient care with involved ward based staff and allied health professionals such as physiotherapists, dieticians, pharmacists, social workers and specialist services such as the rapid assessment interface and discharge (RAID) mental health team.
- Pharmacists provided input into patients' individual treatment by reconciling patients prescribed medications and checking medications were available and appropriate.
- There was access to a wide range of specialist staff such as stoma care, palliative care, tissue viability specialists, which could be requested for advice and input.
- Discharge planning was undertaken with multidisciplinary input. Complex discharges were coordinated by multidisciplinary team meeting and planning in conjunction with community carers and social workers.

Seven-day services

- All patients were reviewed by a surgical consultants on daily ward rounds. Every surgical inpatient was seen at the weekend on ward round, including those that may have been based on other wards.
- Pharmacy services are available between 8.30am and 5pm Monday to Friday and 8.30am – 12 noon on Saturdays and Bank Holidays. Outside these hours the service is covered by an on-call service.
- There was access to laboratories and pathology out of hours and at weekends, with test results and turnaround within an acceptable timeframe.
- There was access to diagnostic services during evenings and weekends except for MRI scans which were only available five days a week.
- Theatres did not provide 24 hour services, they ran during core hours Monday to Friday and an on call service operated on a Saturday. They did complete some emergency surgery but if this was required outside core hours then patients were transferred to other hospitals in the trust.
- Physio and occupational therapists operated a limited service at weekends.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Whilst the majority of staff had received training and annual updates on the Mental Capacity Act 2005, we were not completely satisfied that there was a comprehensive understanding of its application. Staff were very familiar with its relevance to enhanced observations and the deprivation of liberty, but less so on the formal aspects of assessing a person's capacity to consent to treatment, whether that be formal consent to surgery or general consent to aspects of care and treatment. In cases of patients living with dementia and learning difficulties we found staff did not formally document their actions on what they did to assess if patient had the capacity to consent.
- On occasion staff applied a 'mini-mental' assessment as part of the surgical care pathway and believed this was an assessment of a person's capacity. They did not document the actions they had taken and the process they had followed to determine whether a person had capacity or not and this did not fulfil the requirements of the legislation.

- Although they were good at applying a dementia screening process for patients over 65, there did not appear to be an embedded process in cases where this might lead to cause to doubt capacity and how this might then lead to formal assessment of capacity. They could not describe the two stage assessment of capacity as outlined in the legislation.
- Staff gained informal consent from patients when undertaking care and treatment and completed formal consent forms for surgical procedures, however in four of the 10 records we checked the doctor's handwriting on consent forms was illegible.

Are surgery services caring?

Good

We rated caring as good because;

- Staff demonstrated a caring and compassionate nature in the way they went about their work and how they communicated with patients.
- Staff protected the privacy and dignity of their patients when providing care and treatment.
- Patients and relatives were involved in decisions about their care and treatment and were given time to ask questions and have them answered fully.
- Patients told us staff were kind and respectful and that they were kept informed and involved in the care and treatment they received.
- This division received good friends and family test results; which were better than the England average.

Compassionate care

- The patients and carers we spoke with told us they were treated with care and compassion. They said that staff were kind and caring and treated them with dignity and respect.
- During our visit, we witnessed positive and caring interactions between staff and patients. We saw that staff introduced themselves and asked patients permission before carrying out care.
- Cubicle curtains and doors were closed during consultations and patient care and staff sought permission before entering such areas to protect the patient's privacy and dignity.
- The areas we inspected were compliant with same-sex accommodation guidelines, that is men were cared for in separate areas to females.
- The NHS friends and family test (a survey which asks patients if they would recommend the NHS service they have received to friends and family who need similar treatment or care) showed a high response rate of 35.4%. The FFT results showed from November 2014 to October 2015 98% would recommend the surgical wards at Fairfield to the friends and family.
- The hospital also undertakes their own inpatient survey and collates the results on a monthly basis. Feedback from those surveys shows positive results with a small minority of patients expressing dissatisfaction.
- Results from the patient-led assessments of the care environment (PLACE) showed that the trust achieved good results in 2015, we found that any areas highlighted at the time had been addressed by the time of our visit.
- 'Have your say… your time in hospital' leaflets were available in pictorial and written form for people with learning disabilities to provide feedback following their hospital experience.

Understanding and involvement of patients and those close to them

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

Emotional support

- During our visit, we observed emotional support being provided by staff of all grades, who spoke with patients and relatives in a comforting and supportive way.

Surgery

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

Are surgery services responsive?

Good

We rated the responsive as good because;

- Surgery was planned and delivered to meet the needs of the local population and provided suitable premises and facilities for surgical procedures.
- There was attention to individual patient needs and support for those with complex needs.
- The ward environment was very good for dementia patients and there was implementation of many of the recommendations from dementia best practice guidance.
- Complaints were handled and responded to appropriately and the feedback was used to improve services for patients.
- The average length of stay for surgical patients at Fairfield was lower than the England average.
- The hospital met the national target time of 18 weeks between referral and treatment for 95.6% of their patients.
- Bed occupancy was optimum and we saw that patients had good access to treatment and their care was planned and delivered and flowed well from admission to discharge.
- The division had lower cancellation rates than the England average.

Service planning and delivery to meet the needs of local people

- The surgery and anaesthesia division provided pre-planned day surgery, emergency and elective orthopaedic, ear, nose and throat, oral and dental surgery, urology and general surgery on site at the Fairfield Hospital. The local population could receive major surgery and surgery in other specialities such as cardiac, neurosurgery, burns and plastic surgery through Pennine Acute at their other sites or arrangements with neighbouring trusts.
- The facilities and premises in the surgery and anaesthesia division were appropriate for the services that were planned and delivered.
- Ward 14 accepted direct referrals from GPs, which negated the need for them to attend the accident and emergency (A&E) department. If appropriate patients could be treated and discharged, where patients could return home following the procedure or if not could be admitted directly to the ward.
- Co-ordinators held daily bed management meetings to review capacity and organise the availability of beds.
- There was adequate bed spaces in the operating theatre areas and the environment was organised and equipped appropriately to care for patients pre and post-operation. The division was able to determine difficulties with the flow of patients, which enabled them to respond to bottlenecks or delays.
- The division had seven operating theatres, which operated during core hours. They did not run a 24 hours NCEPOD emergency theatre. Fairfield ran an 'out of hours' emergency ear, nose and through theatre but other emergencies were transferred to other trust sites. This enabled local people to access appropriate treatment out of hours and weekends.

Access and flow

Surgery

- Patients were admitted through various channels including pre-planned elective and day surgery, through the A&E department or through a GP referral.
- NHS England suggest patients should see a specialist within 18 weeks of being referred and that trusts should aim to achieve this for at least 92% of patients. Referral to treatment times for Pennine Acute as a whole were achieved for 95.6% of patients as at 11 February 2016 and this included medical treatment. However individual surgical specialities compliance at 31 December 2015 was 94.7% for general surgery, 95.7% for urology, 97.1% for ophthalmology, 94.8 for trauma and orthopaedics, 96.5% for oral surgery, 95.0% for ear, nose and throat surgery, 99.0% for plastic surgery and 97.9% for cardiothoracic surgery.
- Bed occupancy rates for surgical wards on average was 87% from August 2015 to January 2016. This is similar to average figures from comparable trusts and the England average of 89%.
- Between July 2014 and June 2015 hospital episode data (HES) showed the average length of stay for all elective surgery at the Fairfield was 1.8 days, which was lower (better) than the England average at 3.3 days. For elective ear, nose and throat surgery, the average length of stay was 1.0 days, which was lower (better) than the England average at 1.5 days. For trauma and orthopaedic surgery length of stay was 2.9 days which is lower (better) that the England average of 3.4 days and for elective general surgery length of stay was 1.2 days which is lower (better) that the England average of 3.5 days.
- For the same period the average length of stay non-elective surgery 2.6 days, which was lower (better) than the England average of 5.2 days. For non-elective trauma and orthopaedic surgery length of stay was 4.0 days which is much shorter (better) that the England average of 8.7 days. For non-elective general surgery the average length of stay was 0.3 days, which was lower (better) than the England average of 4.2 days. However, non-elective ear, nose and throat surgery length of stay was 2.6 days which is longer (worse) that the England average of 2.4 days.
- From August 2015 to January 2016 8,854 operations were scheduled. Of those 383 or 4.3% were cancelled for a range of reasons. Of those 67 had been cancelled for non-clinical reasons which equated to 0.8% of all operations. Cancellation for clinical reasons may be the patient is ill or has not fasted properly; cancellation for non-clinical reasons includes no available beds, lack of staff, lack of equipment, running out of time etc. These figures are much lower (better) than the average across England figures.
- Trust wide from January 2015 to December 2015 895 were cancelled for non-clinical reasons, of those 10 were not treated within 28 days. This was much better than the average rate across England. This information could not be desegregated to individual hospitals.
- Staff planned for patients' discharge by liaising with community healthcare teams, social services, care providers, district nurses and others in order to facilitate a patient's return to the community.
- Discharge letters included all relevant clinical information relating to the patient's stay at the hospital which were given to the patient and a copy sent to their GP.
- Patients who were cared for outside of their speciality ward are known as outliers. It was common practice for medical patients to be cared for on surgical wards. Staff looking after such patients were competent and capable of doing so and such patients were reviewed by their consultant as part of their ward round and were repatriated as soon as a bed became available.
- We attended one of the hospital's bed management meetings which were held regularly throughout the day to review and plan patient capacity. We saw that staff were able to review and respond to acute bed availability pressures.

Meeting people's individual needs

- The surgery and anaesthesia division operated good system for identifying patients with complex needs particularly those that entered the service through the pre-operative assessment unit. We saw evidence that needs were highlighted and there was forward planning for those with dementia, learning difficulties and mental health problems.
- The trust operate a learning disability service which is part of the safeguarding team. They provide help and advice and a point of contact for patients, carers and staff around the care and treatment of patients with a learning disability on admission, as an inpatient and upon discharge. They ensure that reasonable adjustments have been considered and implemented effectively.

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

Learning from complaints and concerns

- Patients knew how to complain and raise concerns. We saw posters and information on noticeboards and complaints leaflets were available around the hospital which provided information on how to complain.
- The leaflet was clear and simple; it provided information on different ways to complain including email and telephone, it also gave advice on the Patient Advice and Liaison Service (PALS), advocacy services and the parliamentary ombudsman.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- The trust recorded complaints electronically on the trust-wide system. These were allocated to the local managers and matrons who were responsible for investigating complaints in their own areas. Local managers tried where possible to seek local resolutions of concerns rather than going through the complaints process. Where formal complaints were received, the trust set a target to respond to these within 60 days.
- The surgery and anaesthesia division at Fairfield hospital received 13 complaints between December 2014 and December 2015, the majority of those related to patients' clinical treatment.
- Complaints were discussed at divisional governance meetings and complaints groups and learning was circulated by Monday message, team meetings, safety huddles, emails and newsletters.
- During our visit, we saw evidence that wards acted on information learnt from complaints and took action to make changes to improve patients' experience.

Are surgery services well-led?

Surgery

Good

We rated well led as good for well led because;

- The surgery and anaesthesia division was well led on both on a ward level and at divisional level by competent and enthusiastic managers.
- The division maintained and updated a surgical risk register, they were aware of key risks to service provision. They used quality and performance data and audit findings to monitor and act upon issues though trust and divisional governance and team meetings.
- There was a positive supportive culture throughout the wards and departments, staff felt supported and there was good team working and support at all levels.
- Staff were fully aware of the strategy and direction of trust and their role in that vision, they saw positive changes in the last 12 months and anticipated things would continue to improve.
- The division engaged with staff through listening and feedback events. They introduced initiatives to make improvements to the working environments which improved staff inclusion and morale.
- The division engaged with the public through walk arounds and matron listening events to gain feedback on how patients found the division, they focused on areas that they could improve on and made positive changes to services.

However;

- Staff were uncertain about the future of the Fairfield site and were unsure about the future.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We reviewed the risk register for the surgery and anaesthesia division and found that risks were documented and escalated appropriately with action plans in place to address issues identified. The risk register was reviewed and updated at clinical governance meetings.
- A clinical governance system was in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. Regular governance meetings took place to review issues of note. However, we noted that some issues of concern such as delays in surgery for trauma and orthopaedic patients had been raised several times at quality and governance meetings over the past year, yet still no actions plans or resolutions had been implemented to improve the service provided to such patients.
- The division take part in various local and national audits and use the results to make improvements to services.
- Team meetings and safety huddles were held regularly to discuss day-to-day issues and to share and learning from complaints, incidents and audit outcomes. Key information was also shared on notice boards, in staff rooms and by email and newsletters.
- Individual ward managers audited aspects of care and treatment, such as compliance with risk assessment documentation, completion and review of care plans, comprehensive and legible documentation, medicines management and discharge planning. Any issues were raised at staff meetings and safety huddles in order to raise standards.

Leadership of service

- There were clearly defined leadership roles across the surgery and anaesthesia division. Leadership of each clinical group was through a triumvirate arrangement, which was relatively new to the trust and division.
- Theatres at Fairfield had seen seven different theatre managers since 2011. This said this had been unsettling but felt that the current manager had had a positive impact on team morale.
- Staff stated that they knew who the executive team and board members were and that they were visible and responsive.
- Individual ward managers appeared enthusiastic, competent and hard-working and were well thought of amongst ward staff. Nursing staff told us they felt supported and that there were good working relationships within the teams.
- Trainee and junior surgeons told us that senior staff were accessible and supportive and they received good leadership and direction.

Culture within the service

- Staff appeared to be happy working at in the surgery and anaesthesia division at Fairfield, whilst they told us it was very busy, they stated that they enjoyed the work they were doing.
- Staff we spoke with stated felt lucky that the division did not experience the same staffing issues as elsewhere in the trust, which they believed made it a positive place to work.
- They felt well supported within their teams and spoke very highly of their individual ward managers.
- The staff we spoke with said they able to speak up if they had concerns or had made a mistake, they said there was a no blame culture in place.
- The staff survey results from 2015 show the Trust performed in the bottom (worse) 20% of all Trusts, however staff said that morale had improved greatly over the last 12 months and that they could see positive changes in their day to day work.
- Staff we spoke to were uncertain about the future of Fairfield hospital and some staff believed that the hospital would close down in the future, with services relocated to other sites. Whilst they had never been told this by managers or the trust board, they believed it to be true and were resigned to what they deemed was inevitable.

Public engagement

- Surgical matrons undertook listening clinics where they visited wards and spoke to patients, relatives and visitors and gained feedback on the services provided. They used this information to make changes and improvements on their wards and in theatres.
- The division undertook patient surveys to obtain feedback on their services; they used this information to make improvements in quality and service. They used feedback to make changes to the waiting areas in the day surgery ward and surgical assessment areas.
- Information on how the public could provide feedback was displayed in the surgical wards and corridors and information on how to engage with the trust were provided on their internet site.
- Trust information, policies and operational plans including those relating to surgery and procedures were available on the trust website.
- The trust engaged with the public through social media sources and their sites were up to date and current. This system provided information about all services but included information and advice specific to surgery and surgical wards, this was found to be particularly useful in updating patients what to expect regarding their appointments and surgery during episodes of industrial action.

Staff engagement

- Staff received regular communication from the trust and the surgery and anaesthesia division. Communication was circulated to staff regarding wider trust and hospital information and more specific information relating to incidents, complaints, safety and local changes. Communication took the form of meetings with line managers, team meetings and safety huddles.
- The trust also engaged with staff using electronic means, emails, newsletters and through posters displayed on notice boards in staff areas.
- Staff could access information electronically on the trust intranet; there was easy access to policies and procedures, daily safety alerts and updates in practices.
- Staff participated in a feedback process called 'listening in action' in which staff gave feedback to the trust executive board on their concerns, their ideas and what they wanted to change. Staff told us this had a positive impact on their experience and job satisfaction as they felt they could contribute and their contribution was valued.

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

Innovation, improvement and sustainability

- Theatres and the day surgery ward were trialling different procedures which could be accommodated as day surgery cases. They had visited other trusts to ascertain what procedures they were doing and had researched possible techniques. The division recently started undertaking parathyroid operations and the results were positive.
- Theatres were trialling a new shoulder trolley and evidence suggested that it may improve outcomes for certain procedures.

Critical care

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

Information about the service

The Fairfield Hospital in Bury provides critical care services in a six bedded unit to both two level 2 HDU and four level 3 ICU patients. There is an ability to flex the occupancy up to a maximum of five level 3 patients. In addition there is a stabilisation bay, occasionally used overnight by the advanced nurse practitioners. The unit is run by intensivist/ anaesthetists and has a designated clinical lead for both nursing and medicine.

The unit has one side room for the purpose of isolating patients that present an increased infection control risk. No critical care outreach service is provided at the hospital.

The unit submits data to the intensive care national audit and research centre (ICNARC). According to the most recently validated and published ICNARC data for 2015 (January to June) the unit had 127 admissions (around 250 admissions annually). The service is a member of the Greater Manchester Critical Care Network (GMCCN).and for the purposes of governance, critical care sits in the trust's division of anaesthesia and surgery.

As part of the inspection we visited the unit on 25th February 2016. We spoke with senior and junior medical staff, two members of the nursing team, three members of support staff and one physiotherapist. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

We have judged that overall the critical care service at Fairfield Hospital required some improvement.

Services were effective, caring and well led though required some improvement in terms of safety and responsiveness.

The nurse staffing failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7.

There was no critical care outreach service provided at Fairfield Hospital. The hospital was non-compliant with a number of elements of the NICE clinical guidance around the rehabilitation of critically ill patients. The unit contributed data to the intensive care national audit and research database (ICNARC). The most recent data showed that mortality rates were similar to comparable units.

Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect.

There was a problem with delayed and out of hours discharges from critical care. The ICNARC data for January to June 2015 showed that 43% of admissions experienced a delay to their discharge.

Critical care

It was not clear how risks to critical care were being managed. The risk register reported risks that had been identified for years but there was a lack of clarity about mitigating actions, progress and review.

Are critical care services safe?

Requires improvement

Overall, in terms of safety, we judged that the critical care services at Fairfield Hospital required some improvement.

There was a system for the reporting of incidents that staff understood and used. The unit was clean and performed well in comparison with similar units for infection control. There were sufficient numbers of adequately trained staff on duty.

The unit, however, failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff were familiar with the reporting system and were able to give examples of when they had used it.
- We saw a report extracted from the incident reporting system, which showed all incidents reported for the critical care areas within the trust for the period 01/12/2014 to 30/11/2015. The report showed that there had been 69 incidents reported for the critical care unit at Fairfield Hospital. Of these reported incidents there had been four judged to have caused moderate harm to the patients involved. These incidents related to hospital acquired conditions. Eighteen incidents were recorded as causing low or minimal harm with the remainder recorded as causing no harm to the patients involved. There were 19 incidents relating to transfer and discharge issues amongst the reported 'no harm' incidents.
- Incidents were reported and discussed at the monthly critical care directorate meeting.
- Staff told us that incidents and learning was also shared during the daily safety 'huddles' on the unit.
- Monthly mortality and morbidity meetings took place. We saw from the minutes of the September, October and November 2015 meetings that all the unit deaths of the previous months had been reviewed and discussed. The minutes had standard headings for the recording of

lessons learned and duty of candour. We noted that the clinical director for critical care had tended their apologies for all three mortality and morbidity meeting minutes that were shared with us.
- Staff had varying levels of understanding about duty of candour. The trust had introduced training on duty of candour for senior nurses and managers within the trust but the detail and principles had yet to be embedded for all staff. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

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

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- We checked the sluice area and commodes, which were also clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- During the inspection we observed staff appropriately washing their hands, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care. We saw that staff were adhering to the bare below the elbows policy.
- The most recently supplied ICNARC data for the unit (January 2015 to June 2015) showed no cases of unit acquired infections with Methicillin resistant staphylococcus aureus (MRSA) or Clostridium difficile (C diff). Infection rates were generally better than comparable units.
- For the period January 2015 to June 2015 on the ICU at NMGH, in terms of unit acquired infections in blood for ventilated admissions, performance was generally better than comparable units. The data was incomplete for elective and emergency surgical admissions although 98% of admissions were non-surgical so the missing data did not significantly affect the results.

Environment and equipment

- The critical care unit at Fairfield Hospital did not meet the latest building note guidance.
- There was one side room, which did not meet the latest building note guidance in respect of providing source and protective isolation.
- Equipment (monitors, ventilators, pumps etc) was standardised between critical care units in the trust but not with theatres and accident and emergency.
- Details of both planned and unplanned maintenance were recorded and monitored by EBME on the trust wide electronic database system. Planned maintenance schedules were completed according to risk category, with high risk items taking priority. Equipment maintenance was performed by manufacturers, authorised service agents or in house staff. All equipment had a recorded date of when it was last serviced, with each item having its own unique identifier and maintenance history.
- There were resuscitation and difficult airway management trolleys, which were cleaned and checked daily and/or after use.
- There was an emergency transfer trolley and associated kit. This was checked on a daily basis.
- Adjoining the main unit there was an extensive storage area, which also housed the unit manager's office.

Medicines

- The unit used an electronic prescribing system (EPMA), which could be accessed at the bedside.
- The provision of pharmacy support to critical care did not meet the service specification and this may result in poorer patient care and unnecessary expense in medication use. The standard states that all critical care units should have a critical care pharmacist with 0.1 WTE per level 3 bed and 0.1 WTE for every two level 2 beds.
- The drug cupboards and storage was in an open plan area positioned between the two sides of the unit. Drugs were secured within lockable cupboards that had coded locks.
- We saw a locked drug fridge for which temperature checks and records were kept.

- The GMCCN review of May 2015 noted variation on medicines management practices across the trust. For example, drug concentrations and the use of potassium.
- Controlled drugs were stored in separate locked cupboards with the keys being held on the person of the nurse in charge of the shift. Controlled drugs were subject to a daily check.
- There had been four medication related incidents reported in critical care for the 12 month period ending December 2015. Only one of these resulted in patient harm (low), when the hospital ran out of its stock of a prescribed infusion.

Records

- We looked closely at two sets of patient records. The medical/nursing records were paper based and comprised a range of clinical records, assessments and plans. These included for example, VTE risk, delirium, nutritional risk, falls assessments, physiotherapy treatment plans and skin care bundles. One file was used for multi-disciplinary entries. All entries were completed, signed and dated.
- Although entries in records were signed and dated and in most cases included the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on paper charts located close to the bedside. The charts that we looked at were comprehensively and accurately completed and brought together in one place all the patient's physiological monitoring, blood results, care planning and management.
- The unit was using electronic prescribing, which was accessed via a bedside laptop.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. According to the figures supplied 97% of the registered nurses on the unit had completed level 2 safeguarding training for both adults and children.

Mandatory training

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

Assessing and responding to patient risk

- A range of patient risk assessments were undertaken on admission and repeated on and on-going basis as required. These included for example, nutritional risks and the risks of developing pressure ulcers.
- The wider hospital used an early warning score system (EWS). EWS systems were introduced with the aim of providing a simple scoring system, which could be readily applied by both nurses and doctors to help identify early and quickly deteriorating patients. The EWS uses an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation.
- The lack of an outreach team at Fairfield Hospital had been reported in the GMCCN peer review report from April 2015 and was a recognised risk to patient care. We were told that there were plans to introduce limited critical care outreach cover later in 2016.

Nursing staffing

- On the day of inspection both the critical care unit was safely staffed in terms of the numbers of bedside nurses on duty. Based on the intensive care society acuity

standard there should be one nurse for every level 3 patient and one nurse for every two level 2 patients, to deliver direct care. These are the expected staffing levels irrespective of the shift, both day and night.
- The unit did not meet the standard for supernumerary nursing cover. The intensive care society standard states that there will be a supernumerary clinical co-ordinator at band 6/7 on duty 24/7. If the unit was full then the nurse in charge would also have to care for a patient.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- Along with the other critical care units in the trust, the nursing budget was subject to an overall £140,000 cost improvement plan for the coming year.
- No agency nurses were used. Any extra shifts were carried out by the unit's own staff that were duly paid an overtime rate.
- Shift to shift and bedside handovers were undertaken morning and evening.
- We undertook an unannounced inspection visit to the unit on 17th March 2016 and there were adequate numbers of bedside trained nurses on duty. Though there was no planned supernumerary shift co-ordinator.

Medical staffing

- There was a named clinical lead consultant for the critical care unit. We were told by the consultant on duty that there should be seven consultants on the rota but there were currently four vacancies. Gaps in the rota were often covered by consultants from the Royal Oldham Hospital as well as agency staff.
- We were told by the medical staff that all the consultants were anaesthetists with a special interest in critical care.
- The critical care medical rota was also augmented by staff grade doctors. Not all staff grade doctors had specific critical care qualifications.
- There were no trainee doctors working in critical care.
- There was a consultant on duty each day Monday to Friday and available on call out of hours. Saturday and Sundays were covered as on call from 8am. They were supported by staff grade doctors who were also available out of hours. In addition there was also a second on call anaesthetist available.
- There was a structured handover at the beginning and end of each shift. The consultant of the day usually started work ay 8am with the consultant led ward round taking place at 9am each day. Unless they were specifically called in, there was no consultant led ward round at the weekend.
- With only 6 funded beds the consultant to patient ratio was within the ratio recommended by the intensive care society.
- On 17th March 2016 we undertook an unannounced inspection at Fairfield Hospital which included a visit to the critical care unit. This was in response to a whistleblower that had raised some concerns, after the announced visit, about the medical care and cover on the unit. The concerns raised included delays in managing critically ill patients, communication breakdowns between medical staff, an over reliance of medical registrars being used to review and manage critical care patients, refusals to reviewing critically ill patients in accident and emergency, instances of unsafe medical practice and reliance on staff grade doctors to review and agree patients suitable for step down or transfer from critical care when a bed is required for a level 3 patient. We discussed the issues raised with the staff grade doctor on duty during the unannounced visit. However, there were specific aspects within the whistleblowing allegations which we were unable to review at that time. For example, instances of observed alleged unsafe practice. We did establish that when there was no consultant on the unit, such as out of hours, the medical registrar was bleeped to respond to a medical emergency on critical care (and outside critical care in the wider hospital) and then they would decide if the on-call consultant was contacted or not.
- The GMCCN peer review from April 2015 reported that there was a risk that the critical care staff grade at night could be required to support an emergency theatre case (ENT) and therefore leave critical care. This would leave the trust with limited airway skills in the rest of the hospital.

Major incident awareness and training

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

Critical care

- Staff told us of an incident that required evacuation of the unit into the adjoining theatre area. This was carried out as a result of an incident in the critical care unit roofspace. All patients were safely evacuated within five minutes.
- In the adjoining critical care stores area we saw equipment and consumables that had been ordered for use in the event of winter pressures.
- Guidance was available for the management of a pandemic influenza outbreak.

Are critical care services effective?

Good

We have judged that in terms of effectiveness, the service provided at the critical care unit at Fairfield Hospital was good.

Care and treatment was planned and delivered in accordance with evidence based guidance. There were competent staff in place supported by a full-time practice based educator. The unit contributed data to the intensive care national audit and research centre (ICNARC). Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.

Evidence-based care and treatment

- The unit demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the Greater Manchester Critical Care Network (GMCCN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust wide intranet.
- Trust wide there was non-compliance with aspects of NICE guidance 83 'Rehabilitation after critical illness'. The trust had carried out a gap analysis to identify the areas of non-compliance though this wasn't disaggregated for the individual hospital sites. There was no critical care outreach service at Fairfield Hospital so patients were not given the opportunity for a follow up clinic appointment.
- We saw a trust wide critical care audit plan, though it was not clear if all the audits had yet taken place.

Pain relief

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

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- Dietetic advice was available and the dieticians did attend the unit although were not regularly part of the daily ward rounds.

Patient outcomes

- The critical care unit at Fairfield Hospital contributed data to the national database for intensive care (ICNARC), which enabled their respective performance and outcomes for patients to be benchmarked against similar units nationally.
- The most recent ICNARC data shared with us was for the period 1st January 2015 to 29th June 2015. The data showed that for this period there had been 127 admissions to the unit, 52% of which were male and 98% of which were non-surgical admissions. The average age of admissions was 62 years. Staff had told us that the unit predominantly looked after medical patients.
- The data indicated that unit mortality and length of stay for ventilated admissions was higher than in similar units.

- The data also indicated that unit mortality and length of stay for admissions with severe sepsis and/or pneumonia was higher than in similar units.
- The ICNARC (2013) model reported that the unit mortality for the period 1st January 2015 to 29th June 2015 was 1.24, with 34.7 expected deaths and 43 observed deaths. This was within the expected parameters (95% confidence interval) for comparable critical care units.

Competent staff

- Nursing staff were appropriately trained, competent and familiar with the use of critical care equipment.
- There were four trust wide practice based educators working within critical care. Funded by the critical care network they also worked part of their time with the Skills Institute. They were responsible for new starters for the first twelve months of their employment and worked alongside new staff to support them through the Step one critical care competencies. Once the Step one competencies had been completed then nurses were eligible to apply for the critical care course run in conjunction with Manchester Metropolitan University.
- The practice based educators were also responsible for completing the first personal development review (PDR) for new staff.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- All staff were subject to an annual appraisal. According to the data supplied by the trust the latest available figures showed that 46% (against a target of 90%) of staff in critical care at Fairfield Hospital had so far received an appraisal in 2015/16.
- The health care assistants were also able to develop their competencies by undertaking modules in physiological observations such as blood pressure, temperature and pulse. They also had an opportunity to complete the acute illness management course (AIM).
- There were no medical trainee doctors working on or allocated to the critical care unit.

Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place each day on the ICU. The consultant started their shift at 8am and the staff grades at 8.30am. The ward round usually started at 9am. Although members of the multi-disciplinary teams attended at some point during the day they did not always attend at the same time.
- We saw good multi-disciplinary working between nurses and allied health professionals on the unit.
- There was no critical care outreach service at Fairfield Hospital.
- There was no on-site microbiology cover at Fairfield Hospital with no designated cover identified for periods of annual leave. This risk had been identified in the 2015 GMCCN review.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours. The unit was carrying consultant vacancies and gaps in the consultant rota had been covered by staff from the Royal Oldham Hospital.
- The physiotherapy team provided a Monday to Friday service to the critical care unit during the day with an on call service at weekends and out of hours. A 9am to 5pm service was provided on bank holidays.
- Dietetic and pharmacy services were available Monday to Friday and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

Access to information

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

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

Critical care

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

Are critical care services caring?

Good

Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.

Compassionate care

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

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that where possible they understood their care and treatment.
- We asked about the use of patient diaries for patients who were sedated and ventilated. However, whilst the staff stated that they would like to introduce them, they were not using them at the time of the inspection. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- There were no relatives or visitors to the unit during the time of our inspection visit.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- Leaflets were available on the units which gave patients and their families' information about the spiritual care team, which provided emotional support and religious care across all the trust's hospital sites. Referrals to the team could be made at any time by telephone or by completing an online form found on the trust intranet.
- Posters were on display that gave the contact details for the hospital chaplaincy service which was contactable at any time.
- Patients and relatives also had access to the information and advice service (PALS), which had been relaunched in January 2016.

Are critical care services responsive?

Requires improvement

We judged that in terms of responsiveness, the critical care service required some improvements to better ensure that people's needs were met.

There was a problem with delayed and out of hours discharges. The most recently validated ICNARC data supplied by the trust, for January to June 2015 inclusive, showed that there had been 55 delayed discharges. This represented 43% of all admissions in the first six months of 2015. Because of the unit's layout there were difficulties at

times in segregating patients in order to meet the single sex accommodation standard. Breaches of the single sex accommodation standard were reported in accordance with trust policy.

There was no critical care outreach service at Fairfield Hospital.

Service planning and delivery to meet the needs of local people

- The trust had adopted an innovative approach to redefining its vision and values and developing its five year strategy by engaging with staff through a 'crowd sourcing' approach. Crowd sourcing is the practice of engaging a 'crowd' or group for a common goal, usually on-line, often for innovation, problem solving, or efficiency. A key component of the trust's strategy was the transformation of clinical services across the trust. This work was taking place alongside the associated complexities of health and social care re-configuration in Greater Manchester.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.

Meeting people's individual needs

- Patients on critical care were reviewed in person by a consultant intensivist/anaesthetist within 12 hours of their admission.
- Care plans demonstrated that people's individual needs were taken into consideration before delivering nursing care.
- There was no shower or patient toilet on the unit for use by those level 2 patients who had been judged to be clinically ready for step down to a ward bed and whose discharge had been delayed.
- There was no outreach service provided within the hospital. Consequently patients stepped down or discharged from critical care were not always being reviewed in a timely manner.
- We were told that there were some plans for the future development of an outreach service. Staff told us that having no critical care outreach service did on occasions mean that inappropriate referrals were made for admission to critical care.
- The layout of the unit meant that it was difficult to meet the government's same sex standard once a patient had been judged as clinically fit for discharge.
- Interpreting services were available within the hospital if required.
- The senior nurse for organ donation (SNOD) was based on the Royal Oldham Hospital site but did cover the whole trust. All patients for whom a decision to withdraw treatment was made were referred to the SNOD.

Access and flow

- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge.
- There was a problem with delayed and out of hours discharges. The most recently validated ICNARC data supplied by the trust, for January to June 2015 inclusive, showed that there had been 55 delayed discharges. This represented 43% of all admissions in the first six months of 2015.
- Twenty eight percent of all delayed discharges were usually delayed for less than 24 hours although a smaller number of patients experienced a delayed discharge of several days.
- Because of the unit's layout there were difficulties at times in segregating patients in order to meet the single sex accommodation standard. Breaches of the single sex accommodation standard were reported in accordance with trust policy.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns.
- Complaints were made in writing or electronically to the Chief Executive or to the Complaints Department, or via the trust website. The trust website provided details on how to do this and the complaints handling policy was available online. Leaflets were available throughout the trust, detailing the routes available in resolving concerns. Local resolution was encouraged to resolve concerns at ward level and if unsuccessful, the PALS service can attempt to resolve concerns. PALS aimed to resolve concerns but they provided information about

the trust's NHS complaints procedure and provided support if concerns could not be resolved. Effective from February 2016, PALS offices were based at each hospital site.

- The trust complaints annual report was presented to the Board of Directors and shared with commissioners. The trust board received a quarterly Learning from Experience (LFE) report that included details of complaints and PALS contacts received the previous quarter, with associated trends or themes.
- We did not receive any specific information about complaints or concerns from the critical care services at Fairfield Hospital. We did see a spreadsheet detailing incidents and complaints that was tabled at the November 2015 critical care directorate meeting but the page relating to complaints was blank

Are critical care services well-led?

Good

We judged that the critical care service at Fairfield Hospital was well led. There were designated nursing and medical clinical leads. Governance processes were present but yet to be embedded. There was a positive culture with staff and the public being engaged in the development of the service. The longer term future of the service at Fairfield Hospital was still subject to debate and part of wider conversations regarding the on-going provision of healthcare across Greater Manchester.

Vision and strategy for this service

- The trust has recognised in its five year strategy that there are several options for the re-configuration of critical care pathways and services across the whole trust and they remain subject to debate and ultimately public consultation.

Governance, risk management and quality measurement

- Governance processes in the critical care directorate were still evolving since the appointment of the new triumvirate management team. Critical care directorate meetings were held monthly and attended by the directorate's management triumvirate comprising, medical, nursing and business leads. The minutes of the October 2015 meeting state that there was still a need to appoint a governance lead for the directorate. It was not clear how the critical care risks were escalated within the organisation so that the board were aware of them.
- The risk register was held at directorate level. It did contain a number of risks common to all critical care units within the trust, some of which had been on the register for more than two years. For example, the shortfalls in meeting the national service specification for critical care (D16).
- Performance reports were being produced monthly to demonstrate activity within the critical care units.
- The unit contributed data to the intensive care national audit and research centre (ICNARC).
- Due to poor attendance at unit meetings in the past, meetings are held on an informal basis. The unit manager provided a regular newsletter to all staff to inform staff of incidents, lessons learned, patient safety issues and staff updates.

Leadership of service

- There was a new triumvirate management team for critical care in the trust comprising medical, nursing and business managers.
- There was a designated medical clinical lead for critical care.
- There was a designated band 7 nurse in charge of the unit, who staff spoke highly of, specifically stating how supportive they were.
- A number of the nursing team had worked for many years in critical care services at other hospitals within the trust.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were encouraged to report incidents and raise concerns.
- There was no agency nurse usage on the unit.
- We asked staff about their understanding of 'duty of candour' and obtained mixed responses.

Public engagement

- The trust website provided some helpful information about critical care services in general.

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

Staff engagement

- In the wider trust, staff had been consulted and involved in co-creating the organisation's new values, new goals and new five year transformation plan.
- The trust had developed a range of communications to help to staff to celebrate their success such as the 'Pride in Pennine' publications, staff awards, Monday Message and the 'Pennine News' newsletter.

Innovation, improvement and sustainability

- The practice based educators were also involved in acute illness management training (AIMS), teaching on the critical care course, ALS/ILS training, audit and medical devices training.
- The critical care matron (based at North Manchester General) had developed an evidence based delirium strategy, which had been adopted by the critical care network.
- The unit was also involved in the RiCON project (Risk over network). This project aims to improve patient safety within the critical care network by allowing different units to share problems and best practice to improve the quality of care offered to all critical care patients. The project focused on 6 main areas of risk: infection and ventilated acquired pneumonia, communication failures, lack of access to critical care, harm from mechanical ventilation, medication safety and airway safety.

End of life care

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

Information about the service

We visited Fairfield General Hospital on 25 February 2016 as part of our comprehensive assessment of The Pennine Acute Trust. The trust wide specialist palliative care and end of life care service is managed within the division of integrated and community services and operates across all four sites, North Manchester General Hospital, Royal Oldham Hospital and Fairfield General Hospital (FGH) and Rochdale Infirmary.

From April 2014 to March 2015 802 deaths occurred at FGH. From April 2015 to February 2016 the trust reported 2,494 deaths, of which 746 occurred at FGH. Given that the latest figures are only 11 months of data, this is consistent with the previous year's number of deaths.

In this trust end of life patients are cared for on general medical wards. There is a trust wide, consultant led, specialist palliative care team. At FGH there is half a whole time specialist palliative care consultant and specialist palliative care input is led by two specialist palliative care team (SPCT) nurses. The SPCT at FGH received 624 referrals from the 1st January 2015 to the 31st January 2016. There is also a trust wide end of life care facilitation (EOLC) team, which is based at Royal Oldham Hospital.

During our inspection we visited wards 2 coronary care unit, 6, general medical and respiratory, 9, orthopaedic, 11b sub-acute stroke and 21, dementia friendly general medical. We also visited the FGH mortuary and bereavement office. We spoke with 14 staff including ward staff, junior doctors, consultant and SPCT. We also spoke with three relatives and reviewed nine sets of notes.

Summary of findings

End of life services at FGH are requires improvement in safe, effective and well-led and are good for caring and responsive because:

- Care and treatment did not always reflect current evidence based guidelines in that the individual plan of care (IOPC) replacing the Liverpool care pathway was not embedded across FGH wards. Although the two transform wards did use the IPOC, the cascading educational process had not resulted in other wards using this specialist documentation for patients at the end of life. Staff reported that they did not understand the IPOC documentation, did not feel confident using it and required more training before they would be happy to use it.
- There was no cover provided by a SPCT outside of Monday to Friday 8.30-4.30 or at all at weekends. Specialist palliative care clinicians stated that care at these times was poor and gave examples of poor symptom control of patients and a palliative care patient who was moved multiple times late at night, as examples of the deficiencies in care. The 0.5 WTE of a specialist palliative care consultant did provide some on-call care out of hours as did the hospice advice line , but this was limited. The lack of training in symptom control for middle grade staff compounded the lack of specialist palliative care available to patients out of hours and at the weekend.

End of life care

- We observed a number of examples where completion of Do not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation did not conform to the standard set out in the trust policy. On a review of nine sets of notes omissions included, not documenting discussions with family where patients lacked capacity, signing a DNACPR without first discussing the matter with family, no note of why a patient lacked capacity, no note of a mental capacity assessment and illegible signatures.
- In the safe domain there was insufficient specialist palliative care nurses to provide comprehensive cover for the needs of end of life patients.
- In the well-led domain because, trust management was insufficiently engaged with the challenges of end of life care services at FGH. No robust assessment of staffing levels for SPCT had been carried out, but decisions had been made to decrease the number and skill mix of staff. Although there was recognition that the lack of a seven day service was a risk and a proposal to carry out a pilot project to remedy this risk had been developed. The morale of the SPCT was low and there appeared to be little management attention given to the reasons why this should be the case. We heard about stress related sickness absence and staff feeling unappreciated. Clinicians also believed that managers did not share their passion and commitment to EOL services, because of the reduction in staffing levels and reported that did not feel involved in decisions about the future of services at FGH.

However;

- We observed care being delivered to patients, who were at the their end of life, with kindness, consideration and emphathy. We heard from relatives who reported that they and their loved ones were treated with kindness and received professional treatement and care. We also, heard, observed and noted that rapid discharge services were arranged to be highly responsive to the needs and wishes of patients.

Are end of life care services safe?

Requires improvement

End of life services at FGH are safe because:

- There are insufficient specialist palliative care nursing staff to provide a full service to patients at the end of their life. At the time of our inspection, we found that there were two band 7 nurses job sharing a post of 37.5 hours. and additional band 6 WTE was to be recruited. The two staff providing 37.5 hours a week were not able to provide a five day service Monday to Friday. They were only able to provide a service Tuesday to Friday. This was insufficient to meet the needs of patients reaching the end of their life requiring complex symptom management.
- The current system of identifying EOL related incidents does not provide complete coverage of incidents and a more accurate system of identifying them needs to be implemented and audited. This has been identified as a work stream by the trust EOL steering group. Feedback should be given to those staff submitting incident reports so all staff are able to learn from incidents that are related to EOL.

However,

The trust participates in the national care of the dying audit for hospitals (NCDAH) and FGH achieved significantly higher than the national average for the percentage of patients receiving medication for control of five key symptoms as required. We saw evidence of anticipatory prescribing in some medical notes and syringe drivers were readily available to ward staff when required. The standard of record keeping was good in the notes that we reviewed and contained all documentation that we would expect to see. Risk assessments were undertaken appropriately and regular observations were undertaken on EOL patients. Medical support was available promptly for EOL patients who deteriorated. The trust had policies in place for prevention and control of infection and we observed those policies being put in action. The mortuary complied with all infection control requirements. The SPCT had undertaken the required mandatory training. Mortuary staff were a key part of the area major incident plan and had undertaken all required training.

End of life care

Incidents

- The SPCT were aware of how to report incidents and gave examples of incidents they had reported. There were 25 EOL related incidents in FGH between 1/12/14 to 30/11/15. There were no particular themes that could be identified when we reviewed documentation relating to these incidents.
- There was no formal mechanism for staff to receive feedback from the incidents that they reported. The SPCT reported that on some occasions they did receive feedback but on others they did not.
- We were informed that incidents for end of life care were monitored by the manager for end of life care. This monitoring was undertaken requesting a search by key word such as “end of life” and “palliative care”. The incidents submitted by the trust did not appear to relate specifically to end of life care, which made it difficult to assess if end of life care incidents were being adequately monitored.
- Mortuary staff were also aware of how to report incidents and gave examples of the types of incidents they would report.
- Ward staff we spoke with understood their duty of candour responsibilities meant that they had to be open and honest with patients when things go wrong.

Cleanliness, infection control and hygiene

- The trust had policies for the prevention and control of infection, which included a hand hygiene policy and the wearing of personal protective equipment. These were available on the trust’s intranet and staff understood how to access them.
- Alcohol gel and personal protective equipment was available for all staff to use. Ward staff were observed implementing the hand hygiene policy.
- The mortuary was visibly clean and well ventilated. There was documentation to support a regular cleaning schedule. Mortuary staff complied with infection control policies and procedures and this compliance was regularly monitored.

Medicines

- NICE guidelines and the gold standard framework, “Just in Case”, recommend that anticipatory medicines should be prescribed to alleviate the five key end of life (EOL) symptoms of nausea, vomiting, pain, shortness of breath and respiratory secretions.
- In the national care of the dying audit of hospitals (NCDAH), FGH achieved the organisational key performance indicator (KPI) for the prescription of medications for the five key EOL symptoms of of nausea, vomiting, pain, shortness of breath and respiratory secretions.
- The NCDAH includes a clinical key performance indicator measuring how many patients receive medication for the five key symptoms control as required (PRN). In the FGH 80% of patients received medication prescribed to be taken 'when required’ (PRN) for control of the five key symptoms experienced at the end of life. This was better than the England average of 51%.
- All medicines were prescribed using the electronic prescribing and administration system (EMPA). This system contained a palliative care bundle, which included information and guidance about anticipatory prescribing for pain and symptom control for patients’ at the end of life. Medical staff were expected to use the prescribing guidelines for symptom control.
- When patients were placed on the end of life individual care plan, anticipatory medicines were automatically included in the patient’s prescribing plan. However, from the medical notes we reviewed, we observed that when the IPOC was not being used anticipatory medicines were not always prescribed. This did not provide assurance that there was a robust system in place for the prescribing of anticipatory medications.

Records

- The trust used paper based records, with some patient information kept on an electronic system. We looked at nine patient records and all records were legible and signed appropriately.
- From the nine sets of medical notes that we reviewed there was a good standard of documentation. Referrals to the SPCT were noted. The SPCT documented detailed assessments and actions taken such as liaison for hospice referrals. We noted that discussions with families regarding preferred place of care and preferred place of care were documented in medical notes. Multidisciplinary team meetings were documented and plans for escalation of care. In three sets of notes there was not a clear plan for nutrition and hydration documented at the outset of the care plan.

- There was good documentation of nursing care including 24 hour fluid balance, regular observations and regular medication reviews.

Safeguarding

- There were safeguarding policies and procedures in place to protect adults and children. Safeguarding policies were held on the trust intranet and all staff we spoke with were confident to raising safeguarding matters and understood the safeguarding procedure.
- Safeguarding training was included in annual mandatory training. The training provided by the trust was levels one and two for adults and children.
- Information provided by the trust, which was confirmed in staff interviews, indicated that SPCT nursing staff were up to date with all safeguarding training.
- Bereavement office staff and mortuary staff were also up to date with safeguarding training.

Mandatory training

- The trust provided an annual mandatory training programme, to which staff at FGH had full access. This programme included fire awareness, safeguarding, information governance, moving and handling, clinical waste segregation, hand hygiene, infection control and equality and human rights training.
- All SPCT staff, bereavement office staff and mortuary staff were up to date with mandatory training programme.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used in FGH to alert staff to any deterioration of a patient's condition. This was a set of manually recorded observations such as respiratory rate, temperature, blood pressure and pain score. From the records we reviewed all observations were recorded.
- We saw evidence in medical notes that when EOL patients were admitted to medical wards staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure areas and nutrition (malnutrition universal screening tool or MUST).
- We also saw evidence of regular observation rounds being undertaken by ward staff for EOL patients.

Nursing staffing

- The planned number of SPC nurses was, until December 2015, two band seven whole time equivalents (wte). The two post holders had recently retired and were now job sharing for 37.5 hours. This meant that the SPCT was not able to provide full cover Monday to Friday 8.30 to 4.30. At the time of our visit there was no service provided on Mondays. There was no SPCT service available out of hours.
- The SPCT reported that the current staffing arrangements were far too low and that staff were always working alone and with no cover arrangements. SPCT reported that they worked in their own time to try to provide the required level of cover.
- There had been three wte band 7 posts until 2011, when this number was reduced to two. The specialist palliative care consultant observed that when this decision was made, the service had not anticipated the growth in demand that there had been on the SPCT service. The specialist palliative care consultant reported that the current service demand required more wte SPCT members.
- It was reported to us that the second band seven post had been replaced by a band six nurse who started at FGH in April 2016. We saw no evidence of a rationale to support this alteration to skill mix.

Medical staffing

- The specialist palliative care medical staffing was provided by 0.5 WTE of a specialist palliative care consultant. The consultant was content with this level of specialist palliative care medical input.
- The specialist palliative care consultant attempted to review EOL in-patients twice a week but owing to the recent increase in demand, it had not been possible to do this. This meant that some patients who might have benefited from the input of a Specialist Palliative Care Consultant did not. The service had not undertaken any work to quantify the impact of this deficit.

Major incident awareness and training

- The major incident plan was held on the trust intranet. We also saw major incident files in the mortuary and in the bereavement office.
- The mortuary at FGH had 122 spaces and was an essential part of the trust and community major

incident and mass fatalities plan. We were informed that all mortuary staff undergo three training days each year as part of major incident planning to identify where problems might arise.

Are end of life care services effective?

Requires improvement

We found End of Life services at FGH to be requires improvement in effective because:

- We found there was inconsistency in the use of the IPOC across all wards which meant that care and treatment did not always reflect current evidence based guidance, standards and practice for patients at the end of life. The individual plan of care (IOPC) replacing the Liverpool care pathway was not embedded across FGH wards. Although the two transform wards did use the IPOC, the cascading process had not resulted in other wards using this specialist documentation for patients at the end of life. Staff reported that they did not understand the IPOC documentation, did not feel confident using it and required more training before they would be happy to use it.
- There was no seven day service for the specialist palliative care team nurses at FGH, as they did not provide a service out of hours or at weekends. There was limited specialist palliative care input from the part-time consultant post. The impact that this had on patients was demonstrated by different clinicians raising two separate incidents with inspectors, one that related to poor symptom control and one that related to inappropriate bed moves late at night. We were told that clinicians could request information about symptom control from Bury hospice but medical staff did not avail themselves of this facility, possibly due to the lack of clear governance structures to support the decision making process. This did not reflect current evidence based guidance, standards and practice for EOL services.
- Completion of DNACPR documentation did not always conform to the standard set out in the trust policy. On a review of nine sets of patient notes omissions included, not documenting discussions with family where patients lacked capacity, signing a DNACPR without first discussing the matter with family, no note of why a patient lacked capacity, no note of a mental capacity assessment and illegible signatures. This was contrary to the trust's own policy.

However;

- There were a number of areas where FGH demonstrated that it delivered effective care. The SPCT worked in line with national guidelines and local clinical network guidelines. An example of this is that the local clinical network prescribing guidelines had been adopted by the trust EOL steering group. The EOL strategy was based upon national guidelines. FGH achieved eight out of ten of the clinical outcomes in the National Care of the Dying Audit 2014.

Evidence-based care and treatment

- The SPCT worked in line with best practice and national guidelines such as the national institute for health and clinical excellence (NICE). They also worked within guidelines provided by the strategic clinical network for Greater Manchester, Lancashire and South Cumbria. An example of this is that the prescribing guidelines for end of life patients, set by the strategic clinical network, were adopted by the EOL steering group.
- The end of life care strategy was based upon national policies and NICE guidelines. The trust's end of life care plan had previously been based upon the Liverpool Care Pathway, but this was withdrawn some time ago and an individual plan of care (IPOC) had been developed.
- The IPOC was developed in line with national guidelines. The trust decided to implement the IOPC on a rolling programme basis with two wards on each site acting as pilot wards. At FGH the two wards chosen as pilot wards were ward 6, a respiratory ward and 21, an elderly care medical ward. We saw examples of the IPOC being used on both of these wards.
- The SPCT had identified end of life link nurses for all wards, who acted as cascade trainers for dissemination of the IPOC. We found that although staff on all the wards we visited were aware of the IPOC, it was only the transform wards where it was being used on a regular basis. Staff we spoke with said that they were too busy to implement it or that they didn't feel confident using it at this time and would require more training.

- There was an audit plan in place as part of the transform programme. A baseline was established for staff adherence to the available prescribing guidance, the documentation of patients' pain or symptoms and symptom control at the end of life.
- Mortuary staff adhered to the protocol for deaths as set out in the EOL policy.
- There was a trust wide audit carried out of adherence to the national standard, as defined by Hospice UK guidelines, that all deceased persons should be transferred to the mortuary within four hours of death. Across the trust the standard was achieved in 53% of cases.

Pain relief

- Patients' pain at the EOL was assessed using a numeric rating scale for patients who could verbally report pain. A pain tool for assessing patients with cognitive impairment had just been developed but was not in use at the time of inspection. This tool was based on staff identifying visual cues to assess pain. It was anticipated that training would begin on the cognitive impairment pain score in the coming months. The IPOC contained a tool for the non-verbal assessment of pain.
- There was a pain link nurse on every ward who cascaded training and provided support to ward staff.
- Relatives reported that staff were responsive and give pain relief appropriately, as their relative required.

Equipment

- To administer symptom control medication for EOL patients, FGH used McKinley syringe drivers, which are portable, battery operated devices. The syringe drivers were kept in the electro-biomedical engineering department and could be ordered by ward staff as required. Staff reported that there were never any difficulties obtaining syringe drivers when they were required, even out of hours. They also reported that the process for requesting the syringe drivers was straightforward and that they were delivered promptly to the ward by the portering service following a request.
- The maintenance of the syringe drivers was carried out by the medical engineering department. Maintenance of medical equipment was governed by a policy and records of maintenance and service of the syringe drivers were kept. Records indicated that the syringe drivers were serviced regularly.

Nutrition and hydration

- The 2014 NCDAH identified that at FGH 49% of patients had their nutritional status reviewed. This was better than the England average of 41%. The NCDAH also identified that 49% of patients had their hydration status reviewed, which is the around the same as the England average of 50%.

Patient outcomes

- In the NCDAH 2014 FGH achieved four out of seven organisational key performance indicators. These were access to information relating to death and dying, protocols in place for the prescription of medicines for key symptoms at end of life, clinical protocols protecting privacy, formal feedback processes for bereaved relatives.
- The hospital performed better than the England national average for eight of the ten clinical indicators and around the same for the remaining two indicators. This very strong performance in relation to trusts nationally in 2014. These results were achieved prior to the recent retraction in SPCT hours.
- The NCDAH also identified that multidisciplinary recognition that patients were dying was 80% which is much better than the England average of 61%. When we reviewed notes of individuals who were dying, we saw that although patients were not on an IPOC, anticipatory medications were administered and discussions with family about stopping treatments did take place.

Competent staff

- The nurses in the SPCT had undertaken post graduate qualifications and one was an independent prescriber.
- The consultant in palliative medicine at North Manchester General hospital provided a trust wide programme of training for junior doctors. This included training on pain and symptom control, 'do not attempt resuscitation notices', coronial matters, death certification and cremation procedures and requirements. The junior doctors we spoke with at FGH had participated in the training and found it very valuable.
- Staff at FGH confirmed that there was no formal training programme in EOL care for middle grade doctors, which, in the view of medical staff, contributed to the poor level of care provided to EOL patients out of hours.

End of life care

- There was a rolling programme of EOL related education delivered to ward staff by the trust EOL facilitators. The EOL facilitator had been based at FGH for 10 months training staff on the transform wards to implement the IPOC, but the funding for the post was due to end in April., an additional business case was to be developed to further expand the team.

Multidisciplinary working

- There were strong and productive internal multidisciplinary working between the SPCT and other departments, including pharmacy, OT, medical staff and ward staff. These strong relationships were reported by SPCT members and ward staff and we saw evidence of good communication in medical notes.
- Staff reported good liaison between FGH SPCT and community based palliative care teams, GPs, district nurses. On EOL patients' discharge SPCT provided written handover to primary care teams and liaised for a GP same day visit.

Seven-day services

- The SPCT nurses at FGH did not provide a seven day service. As a result of the retirement of the two SPCT nurses.
- Each ward did have an EOL care folder which had been produced by the EOL facilitation team, however, both medical and nursing SPCT staff considered that the service to EOL patients out of hours was poor. Two separate incidents involving EOL patients were cited by staff as an example of the poor service delivered to EOL patients at the weekend. One involved poor symptom control and the second involved frequent moves of a palliative care patient during the night.
- The Bury Hospice provided telephone line support to clinical staff at FGH out of hours and over the weekend. Senior clinical staff considered that junior doctors were unlikely to use this service as there were no clear lines of clinical governance to support the decision making advice that was given by hospice staff. The trust confirmed that there was no service level agreement in place to clarify governance arrangements between hospice staff and FGH staff.
- The SPCT and SPCT consultant did not hold regular weekly multidisciplinary team meetings at FGH. However the trust SPCT did hold weekly multidisciplinary team meetings which were attended by a wide variety of disciplines including chaplaincy, speech and language therapists, occupational therapists, physiotherapists and community teams at the local hospice.

Access to information

- When patients requiring palliative care were discharged, an electronic palliative care handover was completed to notify patients' GPs about discharge and SPCT involvement. If SPCT was not involved during the patient's stay in hospital ward staff completed it for patients with complex needs. We were shown the transfer sheets that staff completed on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy in place and clear evidence of training for staff on how to proceed when patients did not have capacity to consent to treatment or withdrawal of treatment. Information received from the trust prior to our inspection, confirmed that training relating to the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS) was included in safeguarding training.
- We observed that the trust policy for consent and DNACPR was not consistently implemented across the hospital. In the nine sets of patient notes that we reviewed there were different types of departures from the policy on consent and DNACPR. In one instance the DNACPR had been instigated prior to a discussion with family. We saw evidence in the notes that the son had commented on not being involved in a discussion. In another set of notes there was no documentation of a discussion with the patient, no note of why this was the case and no note of whether the patient had capacity to consent to the DNACPR. We saw two examples where a lack of capacity was assumed, no mental capacity assessment was undertaken and no discussion with family noted. In other instances signatures on DNACPR were illegible and other parts of the form were not completed, such as diagnosis, reason for DNACPR and consent to share information.

End of life care

Are end of life care services caring?

Good

End of life services at FGH are caring because:

- Staff at FGH treated patients at the end of their life with compassion and empathy. We were able to observe staff interacting with EOL patients and relatives and commented that their loved ones were treated with kindness and dignity and that nothing was too much trouble for staff. The bereavement survey 2015 reported that the majority of respondents considered that they were treated with respect and dignity by staff. Almost all respondents reported that met their loved ones care needs either always or most of the time. Relatives also reported that they were treated with kindness and compassion.
- There was an ecumenical, multi-faith spiritual care team at FGH, which provided emotional and spiritual support to end of life patients and their relatives and carers. There was a clear statement to provide emotional support only for non-religious patients.

Mortuary staff had put in place procedures for the viewing of deceased relatives, which was compassionate and kind. The viewing room at FGH was clean, but required decoration.

Compassionate care

- Patients at the end of their life were treated with compassion and empathy. We observed staff interacting with patients and their relatives with kindness and consideration.
- The butterfly symbol was used to promote privacy and dignity for patients at the end of their lives and their relatives. The butterfly symbol was promoted extensively across the trust, at training events on publications and on a screensaver. This promotion was to ensure that the symbol and its meaning was embedded into the delivery of care.
- There was a trust wide bereavement survey conducted in 2015. Seventeen relatives responded from FGH. Seventy-three per cent of respondents felt that their relative was treated with respect and dignity by all staff, especially doctors and nurses. Almost all relatives felt that staff met their loved ones care needs either always or most of the time. Seventy six per cent of people said that they were given the opportunity to talk with doctors involved in their relatives care. Forty three per cent reported that they were given the opportunity to be involved in their relatives care. Ninety four per cent also stated that they were given the booklet "help and information for the bereaved".
- The bereavement survey 2015 was discussed at the EOLC steering group in January 2016, where it was decided that a number of actions would be taken to increase the response rate.
- An open visiting policy operated across the trust which FGH implemented. Relatives were given a free parking pass without having to ask for it. The relatives we spoke with really appreciated both open visiting and free parking. Although one relative mentioned that it was very difficult to park at FGH.
- Mortuary staff were compassionate to bereaved relatives when supporting them to view their deceased relative. The process for viewing a deceased relative was designed with the distressed viewing relative in mind. Viewing was by appointment only between the times 8.00am to 5.00pm. The appointment system was in place to avoid more than one family attending the viewing room at one time. There was a separate entrance to the mortuary for families.
- Mortuary staff prepared families for the viewing of their deceased relative, explaining any injuries that they had acquired at or around the time of death.
- The viewing room was clean but required decoration, which mortuary staff recognised. The deceased person was dressed and covered in a dignified and sympathetic manner.
- If relatives wished to spend time alone with their deceased loved one, mortuary staff facilitated this for as long a period as they wanted.

Understanding and involvement of patients and those close to them

- The relatives we spoke with reported that staff involved them in all aspects of decision making about their loved ones. They also reported that they could be involved with care as much as they wanted to be.
- The bereavement survey 2015 found relatively low levels of relative/patient involvement with care. Forty-three per cent of respondents said that they were involved in decisions about their relative's end of life care as much as they wanted to be and only 10% stated that their

dying relative was involved in decisions about their care as much as they wanted to be. The survey reported low levels of patient and relative involvement in decisions about different aspects of care such as preferred place of care, resuscitation status, decisions to stop invasive treatments, symptom management and level of care, for example whether a patient was transferred to an intensive care unit.

Emotional support

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

Are end of life care services responsive?

Good

End of life services at FGH are responsive because:

- The SPCT planned and delivered services to meet the needs of local people. The team had a good understanding of the needs of the local population and communicated well with multidisciplinary teams to meet the needs of local people.
- Relatives told us that they were able to stay with their loved ones and staff provided them with car parking vouchers.
- The mortuary cared for deceased patients according to individual cultural and religious beliefs. It also provided bariatric fridge stores for larger bodies.
- The access and flow arrangements were adapted to the needs of patients at the end of their life. Two rapid discharge schemes were in place at FGH. The first was a rapid transfer of care for palliative patients requiring a fast track discharge to their preferred place of care. We observed this process on one ward where an end of life patient was being transferred to a hospice bed. All arrangements were able to be made within 24 hours, including a rapid transfer ambulance. The second rapid discharge scheme, the rapid transfer pathway for those EOL patients referred to the SPCT and required complex rapid discharge to their preferred place of care in the last 24 hours of life. In addition to observing the rapid discharge process taking place in a very timely manner, we also saw evidence in the medical and nursing notes of these discharges taking place.

Service planning and delivery to meet the needs of local people

- The SPCT had a good understanding of the needs of the local population. Ward staff and the SPCT reported that the team worked as an integral part of the multidisciplinary team, which was evident in the medical notes that we read. However, this work was limited by the recently reduced number of hours in the SPCT.
- The SPCT had good links with community teams outside of the hospital, including GPs, district nurses and community SPCT. These established links supported consistency of care for patients who moved between care settings. We were able to see communication between hospital and community staff in medical records.
- The SPCT communicated with ward staff, regarding patients referred to the SPCT service. We observed

evidence of this communication in medical notes. Ward staff reported that if they required advice and support for complex symptom control, the SPCT would normally respond within 24 hours of referral.

- The SPCT reported that with the reduced level of service, they were not able to see all patients referred to them who required complex symptom control and management. At the time of inspection, there was a five day service and the SPCT would triage referrals in order of complexity. They provided support and advice over the telephone to ward staff when they could not visit a patient.

Meeting people's individual needs

- All the teams and individuals we met were committed to providing individualised care and treatment to end of life patients and their relatives. Once a patient was identified as entering the end of their life, the multidisciplinary team attempted to support individuals with their all their care preferences and needs.
- Where the new IPOC was being used, we saw care preferences documented. We also saw anticipatory medications being prescribed, discussions with relatives about DNACPR and preferred place of care and death. However use of the IPOC was limited to two wards, this did not provide assurance that individualised plans of care were consistently used throughout the hospital.
- Ward staff attempted to move patients who were at the end of life to single side rooms, if there was one available. If a side room was not available patients were cared for in the main bedded areas, with curtains drawn around the bed.
- Relatives of EOL patients were able to sleep at the bedside of their loved one, with ward staff providing a mattress and refreshment facilities. They were also provided with free car parking passes by ward staff.
- There were 14 cold storage bariatric fridges in the mortuary, which enabled the service to store larger deceased individuals with dignity. Mortuary staff adapted their practice according to religious needs. There was a policy in place for accelerated release of deceased persons for cultural and religious requirements. Mortuary staff turned the heads of Muslim deceased to the right and ensured that the faces of the Jewish deceased were covered.

Access and flow

- Referrals to the FGH SPCT could be made electronically or by phone. When members of the team were present, the SPCT triaged the referrals as they came in, signposting them to other services if required. Where possible, those patients deemed as most urgent were seen within the same morning or afternoon session.
- The recent reduction in SPCT nursing hours meant that referrals were more stringently triaged and more telephone advice was dispensed than previously.
- As part of EOL strategy two rapid discharge schemes were in place at FGH. The first was a rapid transfer of care for EOL patients requiring a fast track discharge to their preferred place of care. We observed this process on one ward where an end of life patient was being transferred to a hospice bed. All arrangements were able to be made within 24 hours, including a rapid transfer ambulance. The second rapid discharge scheme, the rapid transfer pathway for those EOL patients referred to the SPCT and required complex rapid discharge to their preferred place of care in the last 24 hours of life.
- There was an increased demand for mortuary spaces due to the increased number of post mortems being requested. Fairfield General Hospital was used as an overspill body store when there were spikes in capacity across the trust.

Learning from complaints and concerns

- Complaints regarding EOLC were dealt in the speciality to which the patient was initially admitted, which could lead to SPCT not being aware of the complaint. The EOLC steering group was aware of this issue and had put in place a plan to better identify complaints relating to EOL matters. In the future the EOL steering group would receive any complaints regarding EOLC. At FGH the SPCT reported no knowledge of any complaints about the service over the past 12 months.

Are end of life care services well-led?

Requires improvement

End of life care services required improvement in the well-led domain because:

- The leadership, governance and culture of FGH did not always support the delivery of high quality person-centred care. EOL care was not identified as a priority within the trust by the executive team and the

work of the EOL steering group was not always prioritised as important against other of trust initiatives. A clear example of this was the delay in implementing an IPOC to replace the Liverpool care pathway meant that only two wards were consistently using the IPOC.
- There had been no coherent review of levels of SPCT nurses, with the numbers and skill mix of the team being depleted with no clear rationale. There was a lack of trust between SPCT clinicians and management, with clinicians reporting very low morale, stress related sickness absence and feeling unappreciated. Clinicians also believed that senior trust managers did not share their passion and commitment to EOL services, because of the reduction in staffing levels and did not feel involved in decisions about the future of services at FGH
- The risks to the service were not always dealt with in an appropriate way. An example of this is although the lack of a seven day service was identified as a risk, there was no realistic strategy outlined to deal with the risk. There was a proposal to carry out a pilot project to provide seven day SPC services, but there was no robust, sustainable strategy outlined to address the required staffing levels for an extension of the service to be successful.

However,

- The trust had a clear statement of vision and values which was driven by national standards of quality of care and recognised safe practice. The statement of vision and values was incorporated into the EOLC strategy, governed by the EOLC steering group. There was a compassionate and caring culture amongst all staff delivering services to EOL patients, which extended to staff in the mortuary and bereavement office when dealing with relatives of the recently deceased.

Vision and strategy for this service

- There was a trust wide strategy in place for palliative and EOLC. This strategy articulated a clear vision for EOLC and identified that EOLC is the remit of the whole trust, not just the SPCT and EOL facilitators. The strategy was based upon national guidelines and good practice as identified in the national policy "ambitions for palliative and end of life care". The FGH SPCT understood the strategy and vision for EOLC and contributed towards its implementation, as far as they were able to given their limited resources. The ward staff we spoke with at FGH demonstrated understanding of the strategy and shared the trust vision for EOLC. This was evident in their commitment to identifying EOLC link nurses for each ward and keeping up to date folders for EOLC in prominent places on wards.
- There was an identified member of the trust board with responsibility for implementation of the strategy, which was the chief nurse. Staff we spoke with at FGH reported that they did not feel supported by the executive team or the chief nurse.
- Implementation and oversight of progress towards implementing the vision was the responsibility of the EOLC steering group.

Governance, risk management and quality measurement

- There were robust governance procedures in place to monitor the implementation of the EOLC strategy and performance of palliative care at FGH. The EOLC steering group met on a quarterly basis and monitored information related to performance and quality for palliative care. This included complaints, incidents and bereavement care. The EOLC steering group recognised that there was a problem identifying relevant data, which resulted in incomplete coverage for the data sets. Actions were being taken to address this which included the introduction of key word searching for incident reports.
- The robust governance procedures for EOLC were supported by a trust governance structure which facilitated regular reporting of EOLC performance within the division of integrated and community services. Quality and performance information and data was communicated within the division by means of monthly highlight reports to the divisional quality and performance committee meeting and the divisional management team meeting. Annual and bi-annual Macmillan service review reports are prepared for the corporate quality and performance committee. The non-executive member of the trust board, with responsibility for palliative and EOLC was a member of this committee.
- There was a trust risk register, which included identified risks for the SPCT. The risk identified was that difficulties providing a seven day service on current staffing levels, as identified earlier in this report. Although this EOL

steering group intended to address this risk by undertaking a pilot of seven day working, there was no evidence that the critical point of this risk, lack of sufficient SPCT nurses at FGH, was being addressed.
- The mortuary was in the diagnostics and clinical support division and mortuary staff attended monthly meetings at the FGH. At this meeting governance issues were addressed and minutes of the meeting were taken and disseminated for all staff.

Leadership of service

- The work of the SPCT and EOLC, was overseen by the trust EOLC steering group. This group was chaired by the lead clinician for specialist and end of life care for the trust. There was trust board involvement in the leadership of the service through the chief nurse and non-executive lead.
- The SPCT was managed by the Macmillan associate lead cancer/palliative care nurse. There was an operational policy in place for the SPCT which included clear statement of governance structures.
- We saw no evidence that the EOLC steering group had identified the challenges involved in establishing a pilot project for seven day working on current staffing levels. We also saw no evidence that trust management or the EOLC steering group had considered the impact of reduced staffing levels either on patients or staff. Although we were told that there was a plan to alter the skill mix of SPCT, we did not see any evidence of a rationale to support this alteration.

Culture within the service

- All the staff we spoke with were dedicated to providing the highest standard of care to patients and relatives and the deceased. Staff demonstrated compassion and understanding to patients and relatives in all the areas we visited. Staff were focused upon the needs of patients, relatives and the deceased, recognising that they had a very important role to play in people's lives at a difficult time.
- We observed that the morale of staff was extremely low in some areas of the hospital and that staff did not consider themselves to be part of a wider trust or involved in decisions about their service.
- All the mortuary staff we spoke with demonstrated that morale was high their and bereavement office and staff felt supported by managers.

Public engagement

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

Staff engagement

- Staff told us they did not feel involved in decisions about the service and reported that they did not feel supported by either their managers or by the trust management.

Innovation, improvement and sustainability

- The EOLC strategy outlined a large number of wide-ranging developments to be implemented in the next year. This included better data collection for the SPCT, evaluation of ward pilots for transform wards, rolling out of the second cohort wards of the transform programme and review of existing gaps in the rapid transfer pathway. The planned pilot project for the transition to seven day working is included in these developments. The SPCT should be heavily involved in these planned developments, but it is difficult to see how this extra work could be achieved under the current staffing levels.

Outpatients and diagnostic imaging

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

Information about the service

Fairfield General Hospital offered 34 outpatient clinics. The outpatient clinics were in the main hospital building at ground level.

Between July 2014 and June 2015 The Pennine Acute Hospital NHS Trust had 701,767 outpatient appointments of which 228,850 were first attendances and 473,482 were follow up appointments.

The trust held 508 outpatient clinics per week. Oral and Maxillofacial surgery; Gynaecology; Ophthalmology and Paediatrics clinics were managed separately within their respective divisions. There were 37 anticoagulant clinics per week across both hospital and community settings. Because the majority of anticoagulant therapy is life long, new to follow up rates for these services did not apply.

In the 18 months from January 2014 to June 2015, there were 215,786 outpatient appointments at Fairfield General Hospital, an average of 11,988 per month. The average numbers of patients attending in the first six months of 2014 to the first six months of 2015 had decreased by 6.7%, an average fall of 825 patients per month.

There had been a 94.4% decrease in attendances at nurse-led activities when comparing the first six months of 2014 to the first six months of 2015, an average decrease of 724 patients per month.

The hospital offered a combination of consultant and nurse-led clinics for a full range of specialities. The clinics included an Anticoagulant Service; Cardiology; Clinical Haematology; Colorectal Surgery; Diabetic Medicine; Endocrinology; Ear, Nose & Throat; Gastroenterology; Geriatric Medicine; Medical Oncology; Pain management; Respiratory Medicine; Rheumatology; Trauma and Orthopaedics; Urology and Vascular Surgery.

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

The hospital also offered a range of diagnostic imaging services to patients, these being: (Radiology) (general radiography (x-rays), CT (computerised tomography) scanning, angiography (pacemaker insertion); ultrasound and vascular ultrasound. Nuclear Medicine and Neurophysiology for the trust was operated out of North Manchester General Hospital. DEXA (Dual energy x-ray absorptiometry) was operated out of The Royal Oldham Hospital and breast imaging services and interventional radiology (IR) were operated out of North Manchester General and The Royal Oldham Hospitals.

The Radiology (X-rays and scanning) were at ground floor level and easily accessible. We also inspected the Pathology Laboratories at The Royal Oldham Hospital. All GP and day-to-day pathology work for the trust went through the Oldham laboratories that were housed in a 3-storey building on site. The building had been commissioned in 2007 and over £17 million had been invested in the services provided. There were Haematology and Biochemistry laboratories at Fairfield and North Manchester General Hospitals but these were essential services laboratories that carried out basic blood tests from within the hospital that were required quickly.

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

Outpatient and diagnostic appointments were arranged by the Booking and Scheduling Department. This centralised trust department was located at Rochdale Infirmary. We visited this as part of our inspection and spoke to the senior manager who was the Interim Lead of Elective Access; we also spoke with, the acting Cancer Services Manager, the Transformation Lead and the Head of Department.

We visited several outpatient clinics at Fairfield General Hospital in the main hospital building. We also visited the Diagnostic Imaging (Radiology) Unit.

During the visit we spoke to 13 staff, including Nurses, Managers and Clerical staff, Doctors and Radiographers. We also spoke to 5 patients. We also held meetings for staff at the trust called Focus Groups that were attended by staff, including staff working in outpatient clinics and diagnostics.

Summary of findings

We rated outpatients and diagnostic imaging services as Good overall This was because

- Staff were confident about raising incidents and told us that they were encouraged to do so. The departments demonstrated that they applied duty of candour, in accordance with the Health and Social Care Act 2008, when things went wrong and that patients received an apology, full explanation and were supported going forward.
- Staffing levels were appropriate to meet patient needs although increased demand on the Radiology services meant some reporting on diagnostic imaging is outsourced overnight to ensure that turnaround times for reports are within national guidelines. The department is actively recruiting to reduce staffing gaps and reduce the amount of work that it is necessary to outsource.
- There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of their roles and responsibilities in regard to safeguarding. Staff were up to date with mandatory training, including level 2 safeguarding
- The departments inspected were visibly clean and staff followed good practice guidance in relation to the control and prevention of infection. Medicines were stored and checked appropriately.
- Departments were of an appropriate size and well set out.
- We observed that the equipment used in the care and treatment of patient's was clean and in good work order.
- An electronic patient record system allowed the filtering out of relevant information and facilitated information being available to different teams very quickly. Not all notes had been scanned and paper notes were still in use for some patients.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients'

Outpatients and diagnostic imaging

wishes into account. The confidentiality and privacy of patient's was respected whenever possible. We saw instances of service planning and delivery to meet the needs of local people.

- We saw good examples of assessing and responding to patient risk, such as the use of the World Health Organisation (WHO) checklist when performing procedures and policies for escalating unexpected findings. Reporting was triaged and risk-based.
- Departmental managers were generally knowledgeable and supportive and had vision improve their services.
- Staff in outpatients and diagnostic services, demonstrated good team working (including multidisciplinary working) and were competent and well trained. There were low sickness absence rates. Staff told us they felt respected and valued.

However

- The trust reported in their missed cancer diagnoses action plan that they had produced a leaflet and banners to support and empower patients, to ask about the tests they have undergone and that these had been distributed in all sites in outpatients and radiology. During the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.
- The trust did not appear to be scanning notes onto the new system on demand, in advance of outpatient appointments or elective treatment. As a result, there was still a mix of paper notes and electronic notes at clinics.Not all notes had been scanned and paper notes were still in use for some patients.

Are outpatient and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging services **Good** for Safe because:

- Staff knew how to report incidents and were encouraged to do so. Feedback from incidents was given to staff; investigations were undertaken in a timely manner and complaints were resolved at a local level where possible. Duty of Candour was exercised.
- There was learning from a review of missed cancer diagnoses and an action plan had been put in place and procedures changed accordingly to reduce the risks of this happening again.
- All outpatients and diagnostics departments inspected were visibly clean and staff followed good practice guidance in relation to the control and prevention of infection.
- Hand hygiene audits, carried out on a monthly basis scored an average of 99.6% compliance.
- In the Patient Led Assessments of the Care Environment (PLACE) audits for 2015 the outpatient areas scored 98.81% for cleanliness in the Kenyon Suite and 100% in the Renshaw Suite for cleanliness.
- Drugs were stored correctly and fridge temperatures checked daily.
- Staff had received safeguarding training and mandatory training was above target levels in all areas.
- There was appropriate signage to safeguard patients from entering harmful areas and equipment had undergone appropriate maintenance checks.
- The WHO risk assessment checklist was used in Radiology to minimise patient risk.
- Nursing staffing levels were good, there was a good staff skill mix and the trust had clear procedures on escalation where safe staffing levels in clinics could not be established. There were few vacancies in the Pathology labs, in general, except in Cytology.
- The trust had a major Incident Policy and this contained details about the suspension of outpatient clinics in the event of a major incident.

However;

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- The trust did not appear to be scanning notes onto the new system on demand, in advance of outpatient appointments or elective treatment. As a result, there was still a mix of paper notes and electronic notes at clinics.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and related investigations.
- There were no "Never Events" (very serious, wholly preventable patient safety incidents that should not occur if the preventative measures are in place) reported in Outpatients and Diagnostics in the 12 months before our inspection.
- There had been no Serious Incidents Requiring Investigation (SIRI) reported in the period 1 November 2015 to 31 January 2016. These incidents require a root cause analysis investigation into the causes and must be reported on the NHS England Strategic Executive Information System (STEIS). From 1 January 2015 to 1 November 2015 there were four serious incidents reported as follows: a delay in the diagnosis of lung cancer; an incorrectly reported chest x-ray (missed diagnosis); a possible bowel perforation incurred during a CT Colonography and an unnecessary procedure carried out due to a delay in acting on updated information about a suspected cancer.
- The radiology Unit has a duty to protect patients from radiation exposure under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. They reported 6 exposure to radiation incidents from 1 December 2014 to 30 November 2015. All caused no harm to the patient.
- The Christie Hospital audited radiation incidents. The Radiation Protection Officer held a 1 to 1 with the staff member who had administered the radiation and they were expected to write a reflection on the incident to learn from the event.
- Outpatient departments reported 30 incidents in total during the period 1 December 2014 to 30 December 2015.
- In outpatients, incidents were discussed at a team meeting that took place every Tuesday morning. Minutes of the meetings were emailed to all staff. Feedback and learning from incidents was fed back to staff at these meetings
- In Paediatric Outpatients, 6 incidents were reported from December 2014 to December 2015. Most of these were risk assessed as "no harm" or "low harm" incidents. Four open incidents had not been investigated. The Paediatric service had had an absence of two Governance roles for 4 months and there was a relatively new post holder at the time of our inspection. They had produced a report at the time of our inspection that showed a range of incidents that had not been investigated. The Matron was experiencing some challenges with staff at ward and departmental level who were responsible for reviewing and initially investigating incidents. The four incidents in Paediatric Outpatients had not been reviewed. On our unannounced inspection, the Matron agreed to review the incidents immediately.
- The Outpatients and Diagnostic Departments used an online incident reporting system on the intranet that was linked to RIDDOR (Reporting Injuries, Diseases and Dangerous Occurrences in health and social care). This provided some assurance that incidents were being managed appropriately and reported to appropriate authorities.
- Staff knew how to report incidents and told us that they were encouraged to do so. They demonstrated that they knew to contact a manager if incidents needed immediate escalation.
- The Health and Social Care Act 2008 Duty of Candour Regulation requires that providers are open and transparent with people who use services and other "relevant persons" (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Staff we spoke with, were aware of their responsibilities to be open and honest with patients and demonstrating duty of candour.

- We were given an example of the trust being open and honest with patients about delays in clinics where details were put on a board in each clinic area and nurses kept patients verbally informed and apologised for delays.
- The trust has a Duty of Candour Policy and an Incident Reporting Policy. The Director for Clinical Governance and the Head of patient Safety were the leads for Duty of Candour. The policy had recently been reviewed and a guidance leaflet created to support staff understanding and engagement. The safeguard incident system had been configured to support managers to record duty of candour and assist the Clinical Governance Department in monitoring compliance across the organisation.
- In June 2015, Duty of Candour training was delivered to 106 senior clinicians, nurses and managers by the Head of Patient Safety and the Trust legal advisors. Radiology had had a specific session delivered at a governance and audit day. In May 2015, the trust commissioned an external company to deliver a 2 day training programme of Root cause Analysis training that included being open. This training was targeted at senior clinicians and managers. The trust told us that 83 people had received this training by the end of 2015. The trust started to roll out an internal programme of investigation training from February 2016 and this included training on Duty of Candour. It is also included in mandatory governance training for senior managers. A review of clinical governance training was underway and corporate induction was to include Duty of Candour.
- During 2015, the trust identified a number of incidents and complaints, indicating that systems for requesting, review, reporting and recording of diagnostic tests required review. This was particularly with regard to cancer diagnoses. In response, a review of 1635 incidents and complaints from the last five years was commissioned. The trust also developed a Diagnostics Improvement Group to oversee an improvement plan. The Quality and Performance Committee approved this plan. 181 of the incidents required a more in-depth review and, at the time of inspection, 159 of these had been completed. Of these, 18 cases were identified as probably preventable; 13 had strong evidence of preventability and 40 were definitely preventable. In addition, five cases did not meet the requirements for Duty of Candour.
- Learning from the missed cancer diagnostic review identified that there was no standard approach or policy for requesting, review, reporting and recording of investigatory tests. There was a lack of systems and safety nets to ensure abnormal results were acted upon, including communications between the trust, the patient and GPs. There was a lack of ownership for following up tests and backlogs in reporting in radiology and administrative processes for patient letters. Knowledge-based, clerical and human errors were also contributory factors.
- The trust response to the review and the improvement plan was to provide additional resources to deal with patient letters within a 10-day timescale and at January 2016, they were above the 95% target. They have developed internal professional standards and policy that was approved by the Safety Committee. They were developing an e-learning programme to advise staff on the correct procedures to be followed. The trust also reported that they had produced a leaflet and banners to support and empower patients, to ask about the tests they have undergone and that these had been distributed in all sites in outpatients and radiology. During the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.
- The Pathology Labs had a zero-tolerance on incorrect sample labelling and any incorrect labels were reported as incidents.

Cleanliness, infection control and hygiene

- All outpatients and diagnostics departments inspected were visibly clean and we noted that staff followed good practice guidance in relation to the control and prevention of infection.
- We saw that staff were bare below the elbow in clinical areas, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines on infection control.
- Hand gel dispensers were plentiful and full in all departments and appropriately placed for use by patients and staff.
- “Sharps boxes” in Outpatients were sealed properly to minimise infection control and were signed, and dated.
- Hand hygiene audits, carried out on a monthly basis scored an average of 99.6% compliance.
- In the Patient Led Assessments of the Care Environment (PLACE) audits for 2015 the outpatient areas scored 98.81% for cleanliness in the Kenyon Suite and 100% in the Renshaw Suite.

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- In outpatients, a trolley mattress audit took place every three months to ensure that mattresses remained fit for purpose, safe for patients and were changed where necessary.
- Data supplied by the trust shows that infection control is part of mandatory training.
- The pathology labs at Royal Oldham Hospital (where most of the pathology work for Fairfield General Hospital was carried out) were visibly clean. Staff understood their roles in hygiene, health and safety and infection control was ingrained. Staff wore personal protective equipment at all times in the laboratory setting.
- There were hand hygiene stations throughout outpatient departments with "Help us fight infection" posters.

Environment and equipment

- The EBME (Electro-Biomedical Engineering Department) was responsible for the maintenance, repair and management of medical equipment. All high risk medical equipment was scheduled for planned preventative maintenance. At the time of our inspection, an inventory of missing equipment was being written and audited. The trust was carrying out a rolling programme of checking all medium risk equipment for safe operation and labelling low risk equipment as "not for maintenance".
- The trust kept a schedule of all x-ray and scanning equipment that showed the date that the contract was due to be renewed and identified any equipment that had been decommissioned. This was broken down by hospital site. We reviewed the records and the schedule was up to date and highlighted forthcoming contract renewals clearly in red.
- Environmental audit cleaning scores in outpatients and diagnostic clinics had a pass rate of 85%. In 2015 the average percentage scores ranged between 90% in William Street Suite Outpatient Department and 100% in Foulds and Wrigley Suite Outpatient Departments. All outpatient departments and radiology scored above the 85% pass rate, on average, for 2015. These were internal audits.
- In the Patient Led Assessments of the Care Environment (PLACE) audits for 2015 the outpatient areas scored 86.67% for condition, appearance and maintenance in the Kenyon Suite and 100% in the Renshaw Suite. This was an external audit.
- Resuscitation trolleys were located in outpatient and diagnostic departments. They were clean and in good order with all the required equipment available. We saw evidence that the trollies were checked on a daily basis and the records available at site went back one month.
- We noted that there were appropriate warning signs on doors in Radiology with restricted access to areas where there was radiation or high power lasers.
- The trust adhered to the Ionising Radiation (Medical Exposure) Regulations [IRMER] and had a policy, procedures and protocols in place.
- The trust had Radiation Protection Supervisors in place in all Radiography Departments to ensure radiological protection requirements were met and they produced annual reports. A Radiation Safety Group that met quarterly and produced an annual report supported theRadiology Departments.
- All GP and day-to-day pathology work for the trust went through the Oldham laboratories that were housed in a 3-storey building on the Royal Oldham Hospital site. The building had been commissioned in 2007 and over £17 million had been invested in the services provided. There were Haematology and Biochemistry laboratories at Fairfield and North Manchester General Hospitals but these were essential services laboratories that carried out basic blood tests from within the hospital that were required quickly.
- The trust used the T-Quest system that automated many of the processes in requesting diagnostic testing. Patient demographics and barcodes were produced by the system for attachment to specimen tubes and clinicians could review the progress of outstanding patient requests.
- The Pathology Services were accredited with UKAS (United Kingdom Accreditation Service) who inspect and accredit the laboratories and ensure that they are operating safely. The last accreditation certificate from UKAS was issued in November 2015.
- The Phlebotomy room was bright and airy; with good personal protective equipment and sharps boxes were labelled and sealed appropriately.

Medicines

- Drug fridges in each department were locked, temperatures were recorded daily and found to be in the recommended range.

- A check on the controlled drugs that were kept in the radiology department (four opioid drugs) found that stocks were recorded accurately, were appropriately stored, sealed and in date
- There were no controlled drugs used in Outpatients.

Records

- The trust had started to use an electronic paper light system called "EVOLVE" and the process of scanning existing health records was on-going. We looked at the electronic patient record system and notes were scanned such that the system can filter out the notes from different hospital departments and medical episodes. A barcode sticker, which is a unique identifier, was used to link the notes to the correct record when scanned and was added to all new handwritten notes or forms.
- Patient notes at Fairfield general Hospital were almost all now scanned onto EVOLVE.
- We were told that Consultants were taking some time to get used to the new system and for it to be fully embedded so the new processes were not running as efficiently as they could have been.
- A pilot of the system showed that there was an improvement in the quality of information recorded; updating information in a timely manner; ease of reviewing the patient's journey; ease of locating required information and ease of identifying who had made previous entries.
- Factors had been considered in the rollout of the new system, including whether the electronic records were easily readable to staff with dyslexia or similar conditions according to trust records.
- Where notes were not present the Automated Letter System (ALS) was used so that referral letters and diagnostic results (where possible) were present when the patient attended clinic
- An audit undertaken by the trust showed that, between October 2014 and September 2015, records were available 99.81% of the time at the time of clinical care. This met the 99% standard.
- Consultants at a Focus Group were critical of the EVOLVE paper light system and complained of receiving empty folders at clinics and having to spend 10 minutes on the computer writing a summary for the file. We have no data on the number of instances where this has happened as the EVOLVE system is electronic so allows the Consultant to view the medical records online.
- Patients in the Phlebotomy clinic were asked for their name and date of birth and blood types were cross-checked to avoid any mix-up of results.

Safeguarding

- In Radiology, staff at Band 6 and above had Level 3 Safeguarding training and staff below Band 6 were trained at Level 2. This included child safeguarding.
- The Patient Administration System (PAS) had a facility to flag safeguarding alerts. We were shown this facility on the system. Staff were able to demonstrate their knowledge of the system and it meant that if there was a safeguarding concern over a patient, this would be highlighted and had to be acknowledged as soon as the patient's records were accessed.
- All staff in outpatients were all trained at Level 2 in safeguarding with the Band 6 and 7 above staff trained at Level 3.
- Staff told us that they were aware how to raise safeguarding concerns.

Mandatory training

- Training due was notified to staff on a weekly basis by the Band 6 Nurse with time allocated to complete.
- Training was delivered by e-learning or face to face though conflict resolution and tissue viability courses were only run two to three times per year so it was not always possible to do the training in a timely way.
- In Paediatric Outpatients, 71% of staff had completed their essential job-related training. These figures were below the trust target of 90%. We escalated this issue to the trust.
- In adult outpatients mandatory training for those staff who were not on long-term sick or maternity leave was above the 95% target.
- In Radiology, levels of mandatory training were at 94%.

Assessing and responding to patient risk

- We noted there was appropriate signage displayed in radiology to warn people about areas where radiation exposure takes place.
- The service had appointed Radiation Protection Supervisors in each clinical area to ensure radiological protection requirements were met and they produced annual reports. A Radiation Safety Group that met quarterly and produced an annual report supported them.

Outpatients and diagnostic imaging

- The WHO (World Health Organisation) Checklist identifies three phases of a procedure, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia or other drugs ("Sign In"); before the commencement of the procedure ("Time Out") and before the patient leaves the procedure room ("Sign Out"). In each phase, a checklist co-ordinator must confirm that the team has completed the listed tasks before it proceeds with the procedure. It is designed to minimise patient risk and avoidable harm whilst undergoing a procedure. The Radiology Unit was using the WHO checklist.
- The Radiology staff held an interventional meeting every morning and this linked to the WHO checklist. For patients having interventional procedures they held a "WHO huddle". As patients came in they went through the initial WHO checklist. They had recently added whether the patient was a smoker to this list and the checklists had been refined to improve them and meet best practice since 2011/12. Just before the procedure took place, they would read out and agree the relevant part of the checklist and then they would use the third checklist at the end of the procedure to ensure that everything was accounted for. Procedures were discussed at the end of the day at a further WHO meeting.
- The WHO checklist ensured that patients who may be at higher risk were identified by asking questions regarding smoking, asthma and diabetes, for example.
- The trust used a sheet for female patients of child-bearing age in the radiology department to ask them about their last menstrual period and risk that they may be pregnant. This was to minimise the risk of a woman who may be pregnant being exposed to radiation. In cases of doubt, a pregnancy test was undertaken.
- Resuscitation trollies were available in both the radiology and outpatients. We looked at the log sheets and saw that the trollies were checked daily.
- In pathology laboratories, we saw that there was good exceptional reporting with unexpected results telephoned through to the request initiator immediately.
- In Haemoglobin testing, staff looked for lifelong anaemias such as sickle cell and thalassaemia majors. If either were suspected a second sample was requested for further testing and a coded comment was given to the clinicians to suggest further testing for these conditions as patients are supposed to be counselled if these conditions are being tested for. Sickle cell disease (SCD) and thalassaemia are inherited blood disorders. If you are a carrier of sickle cell or thalassaemia, you can pass these conditions on to your baby. All pregnant women in England are offered a blood test to find out if they carry a gene for thalassaemia, and those at high risk of being a sickle cell carrier are also offered a test for sickle cell. If the mother is found to be a carrier, screening is also offered to the father.
- In antenatal blood screening, all abnormal results were stored on the trust's internal "U" drive with coded comments, if sickle cell was suspected, and the Antenatal Department was called. Midwives chased up the results. An "at risk" couple was referred to the Sickle Cell service. The lab received around 160 abnormal antenatal results per year.
- Although patients requiring admission to hospital from clinics was a rare occurrence, this was facilitated well. We were given an example where a patient had been admitted from an ENT clinic the previous evening and a nurse waited with the patient until they were found a bed to maintain patient safety.

Nursing staffing

- The trust had clear procedures on escalation where safe staffing levels in clinics could not be established.
- Nurse staffing allocation in the main Outpatient Department clinics was planned against those clinics that were scheduled. It was variable on a session by session and week by week basis due to varying templates, cancelled clinics and additional clinics scheduled.
- The electronic rostering system (E-Roster) was unable to capture the staffing requirements on a daily basis (as it could for inpatient wards) and there was therefore no facility to extract planned versus actual data.
- The trust took the view that the role of a registered nurse in clinics was to ensure the smooth facilitation and co-ordination, especially where there were large numbers of patients who required diagnostic tests prior to their consultation. They used Band 5 Nurses in certain clinics where additional knowledge and skills were required however we noted that there was no Specialist Nurse input. Registered Nurses also had responsibility for the supervision of student nurses.
- Numbers of nurses and required grades were assessed based on the complexity, type and location of the

clinics. The trust had banded each type of clinic and established the minimum nursing levels. For complex clinics a registered nurse was always required; Interventional clinics required a registered nurse most of the time due to intervention procedures but certain clinics may not; Geographic/Supervisory clinics required a registered nurse due to the location (e.g. it was in a remote building) or supervisory requirements and Non-Interventional clinics did not require a registered nurse though supervision was made available.

- The trust supplied details of how each type of clinic was graded; for example, breast clinics were graded as complex, requiring a Band 5 Nurse to support surgical interventions, administer complex dressings; deliver 1:1 care and support patients who are given bad news.
- Outpatients had 36.5 nursing and health care assistant (HCA) staff. The staff were managed by one Band 6 and one Band 7 Nurse who split their time between Fairfield General and Rochdale Infirmary. The greatest numbers of staff were Band 5 Nurses (9.03 FTE) and Band 2 HCAs (15.71 FTE).
- The hospital was recruiting for Band 2 Health Care Assistants. Trust data shows that there were 6.61 WTE vacancies for Healthcare Assistants in Outpatients at 31 December 2015. At February 2016 the vacancy rate was 1.5 WTE

Allied Health Professionals

- At November 2015, there were 38.50 radiology staff in post against an establishment of 41.78. There was a shortage of three Band 5 Radiographers and 1.28 Senior Radiographers.
- Sickness rates in Radiology were at 5%. There was one Radiologist on long-term sick leave.
- There were ten band 5 radiologists on duty each shift and 34 employed in total. Two agency Radiologists were being employed to fill staffing shortfalls.

Pathology

- There were few vacancies in the Pathology labs, in general, except in Cytology. The Cytology Department was carrying vacancies that they could not fill because of the loss of the gynaecology cytology contract to another trust. In addition, three staff were off long-term sick and they had been unable to get locum support. Existing staff were carrying out overtime to get the work done and minimise the backlog.
- The biochemistry lab ran for 24 hours a day, 7 days a week. A number of staff worked late shifts with two overnight staff in haematology and one in biochemistry.
- Microbiology had 88 staff. They had a full complement of Consultant Microbiologists. There was an on call service at night with one Biomedical Scientist on duty. The Department was interviewing for 2 posts at Band 4 during the week of inspection and for two Band 6 posts the following week. There were also some vacancies at Support Worker grade. Support Workers prepared the samples for scientists to examine the following day. Band 4 Practitioners prepared culture plates for positive cultures and this made the work less labour-intensive for Band 6 Biomedical Scientists.
- The Microbiology Services Manager was on a 7-week on call rota for out-of-hours. This meant that for one day a week (Monday, then Tuesday etc.) they would be responsible for the whole hospital site between 5PM and around 10PM and would need to sort out any staffing problems or other issues e.g. a staff member not turning up for work in A & E. Following the seven-week rota there was a period of 8 weeks off. The Manager told us that that the rota system made the managers work better as a team across the site and understand each other better and clinician pressures. The morning after an on-call shift, the manager only undertook admin tasks to minimise the risk of clinical errors.

Medical staffing

- Consultant Radiology cover was provided on site from Monday to Friday 9AM to 5PM.
- General on-call Radiology services was provided on weekday evenings from 5PM to 9PM by a trust-wide rota supported by trust Consultants. 9PM to 9AM general on-call services were provided by a contractor reporting Radiologist 7 days a week. On call services at weekends 9AM to 9PM were provided by a Consultant.
- Interventional Radiology was provided Monday to Friday 9AM to 5PM. Out of hours was provided by a trust-wide rota 5PM to 9AM on weekdays and 9AM to 9AM on Saturdays and Sundays.
- Vacancies for radiologists across the trust was noted on the risk register and Speciality Trainees were encouraged to apply for vacant posts.
- Consultants criticised the induction for locums who were just given a manual of things they should know. They also said that there was often a problem with

timely access to IT systems for new locums. This could pose a risk to patients if the Consultant was unaware how a Department operated and a proper 1:1 induction had not been undertaken with them.
- Outpatient consultants reported no gaps at consultant level. Consultants shared secretarial services. Where clinics were cancelled or delayed due to no Consultants, this was generally because they were delayed in Surgery, often at another location.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected the outpatients and diagnostic imaging services for effectiveness but did not give a rating for this domain.

- The pathology services had invested heavily in technology and equipment to enhance the delivery of effective care and treatment.
- Staff were aware of the National Institute for Health and Care Excellence (NICE) and policies based on NICE guidelines were in use in outpatient and radiology departments.
- The follow-up to new rates rate for appointments was lower than the England average and had been so since August 2014.
- The workload and turnaround times in laboratories was monitored to maximise patient outcomes.
- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme.
- All staff in the trust were involved in "raising the bar on quality" where ten key action points had been introduced to make the trust and its services the best it could be for staff and patients.
- Staff development and further education was encouraged within the services. Staff had received appraisals and 1:1s.
- Electronic systems used by pathology enabled results to be obtained by Consultants and GPs faster than before their introduction and minimised the risk of paper records being lost.
- Some services ran 7 days a week, 24 hours a day. Running other services on weekends was being considered according to demand.
- There was good multidisciplinary working between services.
- Consent forms were audited to ensure consent was appropriately and consistently gained, prior to treatment.
- Best interest meetings were held and appropriately documented, where patients lacked capacity.

However:

- Not all referral to treatment times for each type of clinic was available on the NHS Choices website.

Evidence-based care and treatment

- The pathology services had invested heavily in technology and equipment to enhance the delivery of effective care and treatment. For example, the biochemistry lab had an automated haematology system for analysing bloods that could analyse up to 800 tubes per hour and provided automatic sample validation.
- In the microbiology labs, boric acid containers for urine cultures maintained the microbiological quality of the specimen and prevented overgrowth of organisms during transport to the lab. The department also had brand new blood culture machines though these were still in the verification phase at the time of inspection. There was a MALDI (Matrix-Assisted Laser Desorption/ Ionisation) in the lab that could identify bacteria in minutes using lasers, rather than a number of days growing cultures.
- The Cellular Pathology lab had recently acquired a Microwave Tissue Processor that was undergoing the validation process at the time of inspection. This would allow for faster diagnosis which meant a better service for patients.

Outpatients and diagnostic imaging

- The needs of people living with dementia were considered in planning care and treatment. Staff undertook an online dementia training course and there was a Dementia Link Nurse to offer more expert advice.
- Staff were aware of the National Institute for Health and Care Excellence (NICE) and policies based on NICE guidelines were in use in outpatient and radiology departments.
- The trust had an action plan around misdiagnosis of cancers and this included the development of a trust wide policy incorporating NICE guidelines and the National Patient Safety Agency 16 guidelines. New standard operating procedures were also in development.

Nutrition and hydration

- Drinking fountains were available to patients in outpatients and radiology departments.
- There was a small cafeteria within the outpatients departments for those patients who wanted food or drink whilst in the hospital. There was glucose and biscuits available in clinics for diabetic patients. Food could be provided for patients who were waiting a long time for an ambulance to take them home.

Pain relief

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

Patient outcomes

- The Pathology Department was undertaking an audit on physicians checking on results in a timely way, using the available electronic systems.
- The workload and turnaround times in laboratories was monitored by Pathology Managers to maximise patient outcomes.
- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme. It consists of meeting criteria in four domains of service provision, namely, patient experience; facilities; resources and workforce and safety and clinical. The departments were intending to submit for accreditation by the end of June 2016.
- The follow-up to new rates for clinic attendances across the trust as a whole was in the mid to low quartile when compared to other trusts. At Fairfield General Hospital the rate had been lower than the England average since August 2014.
- New appointments accounted for 32% of appointments whilst 58% were follow-up appointments. This was in line with expected ratios and was aligned to other sites in the trust.
- 9% of patients did not attend (DNA) their appointments. Figures for patient and hospital cancellation of outpatient appointments were not recorded separately so we were unable to review or assess them.
- All staff in the trust were involved in "raising the bar on quality" where ten key action points had been introduced to make the trust and its services the best it could be for staff and patients.

Competent staff

- Healthcare Assistants in outpatient clinics were able to undertake an NVQ which in turn enabled them to carry out venepuncture and physiological measurements.
- The trust were supportive of staff undertaking further education and training and staff were encouraged to undertake further training in areas of interest. There were a number of Link Nurses in each department who had been given enhanced training in specialisms and were able to train other staff accordingly and give advice where necessary. They trained staff in any new procedures or equipment, for example, the use of new types of dressings.
- The Pathology Unit was a training base for the region and had a working relationship with a local University who provided some funding. The service often employed people they had trained.
- In adult outpatients 100% of staff had appraisals at November 2015 according to data supplied by the trust
- Staff had regular 1:1's with the band 6 Nurse in outpatients and were confident to raise any issues as they arose.
- 75% of paediatric staff were up to date with their appraisals in outpatients.

Outpatients and diagnostic imaging

- No nurses in Paediatric Outpatients had APLs (Advanced Paediatric Life Support) training. This was escalated to the trust for immediate action.
- Staff appraisals in radiology were at 77.78% for Additional Clinical Services and 60.71% for Allied Health professionals according to trust data at November 2015. We do not have more up to date data with the Radiology Manager did tell us that at least 4 further appraisals had been carried out since the figures were last published.
- Staff in radiology attended medical device training. We were told that Outpatient staff had recently had a training day via the Urology Department on the use of a new bladder scanner.
- The Outpatient Manager told us that nurses undertook clinical competencies under supervision of a qualified nurse before being allowed to undertake procedures, for example, finger strapping. Competencies were signed off on a form.
- There were clinical tutors available to radiography students and the trust worked closely with local universities in student training according to the Radiology Manager.
- Leadership courses were attended by staff leading teams according to the Managers that we spoke to.
- The hospital had nurse-led clinics in Urology; Neurology; Rheumatology; Palliative Care; Cardiology and Diabetes according to data supplied by the trust.

Multidisciplinary working

- The Microbiology team in Pathology Services worked closely with Link Nurses in the hospital who were knowledgeable in infection and prevention control and this helped in ensuring that appropriate blood cultures were examined where infections were suspected.
- Where a result of "Skin flow Significance Doubtful" was found in Microbiology, this was conveyed to the clinicians in real time.
- If a particular Doctor was sending through culture samples that showed high contamination rates, this was raised with the Consultant at the earliest opportunity.
- The Haematology team worked closely with clinicians where lifelong anaemias such as sickle cell or thalassaemia majors were suspected to enable the patients to be offered counselling at the earliest opportunity.
- There was an efficient collection and delivery service of pathology samples between all the sites with samples being delivered throughout the day. We spoke to a delivery driver who told us that they collected samples from all hospital sites and delivered them throughout the day.
- There was evidence of good multidisciplinary team working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked as a team according to the staff and Managers that we spoke to.
- The Radiology Department ensures that it meets clinical guidance for turnaround times for diagnostic imaging reports by outsourcing a work overnight to private companies or individuals though the trust acknowledge this places financial pressures on the department.
- The electronic patient records system allowed clinicians to access other pathways that the patient may be on which allowed ongoing care to be co-ordinated and communication between different teams.
- There was good communication with GPs and District Nurses regarding leg ulcers; orthopaedics and wound care dressings according to the Outpatient Manager.
- Nurses referred patients for physiotherapy where appropriate. The referral forms were completed by a Consultant after a decision was taken that this was the appropriate course of action.

Seven-day services

- Paediatric outpatient appointments were only available from Monday to Friday.
- The Biochemistry Laboratory in Pathology Services ran 24 hours, 7 days a week with a number of staff on the late shift and two overnight staff in haematology and one in biochemistry.
- The Microbiology Lab was undergoing a study on whether the service needed to be provided on a 24/7 basis at the time of inspection though they did not have enough technical staff to process cultures at night. There was an on-call service at night with one Biomedical Scientist on call from an on-call room or home.
- There was no weekend service in the Cellular Pathology Labs because biopsies in the hospital sites were generally collected only on weekdays. However, when the Endoscopy department occasionally ran a Saturday service to reduce backlogs, this could result in the Histology Lab starting on a Monday with 50-60 biopsies to examine which added pressure to work turnaround times.

Outpatients and diagnostic imaging

- Some outpatient clinics were arranged on evenings or Saturdays but these were ad hoc and addressed waiting list backlogs. In general, outpatient clinics only ran on week days.
- X-rays and CT scans were available 7 days a week for inpatients. There was a Radiologist on-call at night in the department. Interventional radiology was available trust wide after 5PM and at weekends.

Access to information

- The trust used the T-Quest system that automated many of the processes in requesting diagnostic testing. Clinicians in the trust and in 160 local GP practices could review the progress of outstanding patient requests and reports without having to wait on paper-based results. The system had significantly improved the quality and speed of test request and results between primary and secondary care settings.
- The trust also used the Keystone system to disseminate pathology, radiology and clinical correspondence documentation to its GP community. Clinicians could view test results from other care settings, allowing them to read test results in context, to better evaluate treatment choices. Discharge summaries were also available on the system.
- Cellular Pathologists used Winscribe to dictate their reports that were typed by medical secretaries. Samples were photographed and photos were embedded in the reports.
- The Healthviews system was shortly to be rolled out across outpatients, diagnostics and pathology departments that enabled the electronic ordering of diagnostic tests and results reporting. It also enabled clinicians to log in to a number of different systems at one time so it integrated with the electronic health records system. The system would be available 24 hours a day so would significantly reduce requesting and reporting times.
- Consultants were issued with hand-held electronic devices that could access the Evolve medical records system.
- The electronic patient record system held full historic patient notes. They had been scanned such that details of relevant medical conditions could be filtered out and were easily accessible to the clinicians.
- Outpatients departments had a wide range of patient information leaflets and were available in racks in the relevant clinics. However, the racks were such that the leaflet titles could not be read so it was not easy for a patient to find the appropriate leaflet quickly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent forms were available in all clinics. Some patients consented to treatment whilst in clinic but the majority of patients signed consent forms at the pre-op stage of their treatment.
- The Mental Capacity Act(MCA) is in place to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of liberty so they can be given care and treatment in a hospital or care home. Training on DoLS was available to all staff in Outpatients and Mental Capacity Act training is part of mandatory training.
- Training on the Mental Capacity Act was given to staff as part of the Level 2 Safeguarding course.
- Outpatient's staff reported few issues with mental health and mental capacity. Staff were able to escalate concerns when they were unsure about the capacity of a patient to make an informed decision and contacted someone from the Safeguarding Team for advice. Patients under the care of a mental health trust had their own outpatients departments as part of that trust.
- Consultants held multidisciplinary best interest meetings to decide the best course of treatment, where the patient lacked capacity according to the Manager.
- Consent forms in radiology were audited. A recent trust audit showed that forms were legible, signed and dated correctly with the status of the practitioner.
- "Best interest" meetings took place between the radiologists and the referring team if the patient lacked mental capacity. Staff were aware of the issues around the mental capacity of female patients and the date of their last menstrual period. Pregnancy tests would be requested before exposing the patient to any radiation where there was any doubt.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging services **Good** for Caring:

- Kind, caring and compassionate staff delivered outpatient and diagnostic services in Fairfield General Hospital. They were observed to be polite, friendly, helpful, and made efforts to alleviate patient fears.
- Staff were encouraged to "think compassion" in every action and interaction and to be approachable and respectful. This was from "Raising the Bar on Quality" that was being implemented across the trust.
- The hospital had a number of clinical nurse specialists who were knowledgeable and available for patients and relatives to discuss their condition.
- In the Patient Led assessment of the Care Environment (PLACE) assessments for privacy, dignity and wellbeing, the hospital scored higher than the England average in the Renshaw Suite Outpatients Department.
- There were staff in the Breast Care and other clinics who had received advanced training in breaking bad news and supporting patients.
- Information leaflets and letters explained what patients could expect during their care and treatment.

However:

- In the Patient Led assessment of the Care Environment (PLACE) assessments for privacy, dignity and wellbeing, the hospital scored lower than the England average in the Kenyon Suite Outpatients Department.

Compassionate care

- We observed that staff were friendly and supportive and reception staff were knowledgeable and able to help patients with queries other than about their outpatient appointment.
- All consultations and examinations took place in a closed examination room. There was appropriate signage on doors to indicate where a room was in use. This assured us the patient dignity and privacy was maintained.
- The hospital had a Chaperone Service and patients with carers were encouraged to bring their carer to appointments. Nurses acted as chaperones during patient examinations when requested by a Consultant. We observed the nurses giving reassurance to patients.
- Staff were encouraged to "think compassion" in every action and interaction and to be approachable and respectful. This was from "Raising the Bar on Quality" that was being implemented across the trust.
- The Outpatients Department reported that they had carried out no local patient surveys recently so they had not gauged any detailed views about how patients rated the service and their treatment.
- In the Patient Led assessment of the Care Environment (PLACE) assessments, the hospital scored 75% compliance in the Kenyon Suite and 87.5% compliance in the Renshaw Suite for privacy, dignity and wellbeing. The national average score was 86% compliance.
- At the time of inspection, the Radiology waiting room was full and some conversations at the reception desk could be overheard by other patients.
- Seating in the palliative care clinic had previously been re-arranged to avoid patients hearing what was happening in consulting rooms.
- One patient said that the care they received was good and that the Consultant was brilliant though did have trouble in contacting their specialist nurse over the Christmas period.
- A Phlebotomist had received a special thank you from the Nursing Sister for going above and beyond in helping patients.

Understanding and involvement of patients and those close to them

- Patients were given appropriate follow-up appointments based on when their test results could be expected. Results could be expected back in no longer than six weeks. Where results were expected within two weeks, the patient was given a further appointment in two weeks.
- One patient told us that they not like travelling to different sites for the next available appointment. They would have preferred to travel to their nearest hospital for all their appointments.
- Two patients told us that they had not had to wait long in clinic before they were seen and had had a positive experience overall.

Outpatients and diagnostic imaging

- We observed nurses keeping patients informed about waiting times and apologising for any delays.
- The Outpatient Manager told us about a patient with learning disabilities who had attended the previous day. They were made aware that reasonable adjustments needed to be made for the patient and had ensured that there was a private room for the patient and their parent to sit and had made an earlier appointment at their request.
- We were told that, on occasions, prisoners were brought into the hospital without notice and that they always supplied a room for the prisoner and Prison Officers to sit in and carried out an appropriate risk assessment.

Emotional support

- Breast care specialist nurses had undertaken the advanced communication skills training and were able to give emotional support when breaking bad news to patients.
- The Manager told us that there were staff available in outpatient clinics who could break bad news to patients and offer emotional support.
- Information leaflets regarding different conditions, such as vascular; ENT; colorectal and urology were on display where those clinics were held. The leaflets explained the condition and possible treatment plans and helped to alleviate patient fears and concerns the patient may have had about their condition and treatment.
- In Radiology we looked at some appointment letters that clearly explained to patients the procedures they would undergo and tried to alleviate any patient fears or concerns about their treatment
- The hospital had a number of specialist nurses in the clinics who were able to talk to and advise patients on their diagnosis and condition.
- Staff told us that patients wrote letters and thank you cards to the department about the care and support they had received and that these were sometimes added to the Monday message from the Chief executive.

Are outpatient and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging services Good for Responsive: This is because

- It was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average, and the cancer waiting times for the trust were consistently better than the England average.
- Service planning of clinics met the needs of the local people. There was some flexibility in clinic times and numbers in response to waiting lists.
- In the Pathology Services, specimen identification and flow was well-managed.
- Services had things in place to meet peoples' individual needs, such as leaflets and videos in different languages; interpreting services; braille and large text services; British Sign language services; bariatric equipment and services for people with learning disabilities or who were living with dementia.
- Complaints were handled in line with trust policy and were resolved locally wherever possible. Learning from complaints took place.
- However
- The percentage of people waiting more than six weeks for a diagnostic test had been worse than the England average since July 2015.
- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average and the cancer waiting times for the trust were consistently better than the England average we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level. Work is being undertaken with the trust to clarify the current position.
- The numbers of patients failing to attend their appointments was worse than the England average and there were no clear plans in place to improve this situation.
- We have seen instances where complaints were not responded to within the expected timelines and there appeared to be a need to embed the recently renewed policy, clear complaint backlogs and fill staffing vacancies on the Complaints Team.
- **Service planning and delivery to meet the needs of local people**
- In the 18 months from January 2014 to June 2015, there were 215,786 outpatient appointments at Fairfield General Hospital, an average of 11,988 per month. The

average numbers of patients attending in the first six months of 2014 to the first six months of 2015 had decreased by 6.7%, an average fall of 825 patients per month.

- The hospital offered a combination of consultant and nurse-led clinics for a full range of specialities. The clinics included an Anticoagulant Service; Cardiology; Clinical Haematology; Colorectal Surgery; Diabetic Medicine; Endocrinology; Ear, Nose & Throat; Gastroenterology; Geriatric Medicine; Medical Oncology; Pain management; Respiratory Medicine; Rheumatology; Trauma and Orthopaedics; Urology and Vascular Surgery.
- Across the trust, the top five speciality clinics by volume of attendances were anticoagulant services; trauma and orthopaedics; obstetrics; ophthalmology and urology. They made up 46% of all attendances. Anticoagulant services had the highest number of attendances. Anticoagulant patients could also be seen at the Community Clinic of their choice.
- The trust was working with commissioners to roll out new anti-coagulant drugs that do not require regular blood tests, meaning patients would not have to attend the hospital as frequently.
- Podiatry services for people living with Diabetes were available Monday to Friday at least one of the four hospital sites.
- Outpatients and Radiology departments within the hospital were clearly signposted.
- Nurses were allocated a late shift every week to facilitate late-running clinics or late running of Patient Transport Services collecting patients. This could be up to 9PM. Patients were not left unattended if waiting for an ambulance to take the home.
- At 4:45PM every day, the staff nurse on duty checked all clinics for late running and allocated staff to manage the clinics until all patients had left. Staff were given time off in lieu for working extra hours. This provided assurance that the service had taken all reasonable steps to ensure that the needs of people using the service were being met.

Access and flow

- In the Pathology Services, specimen identification and flow was well-managed. Samples were collected and delivered on an hourly basis from collection points across all the hospital sites and were sorted immediately upon arrival at the Pathology Reception.
- More urgent samples, such as those for patients in A and E were easily identified and prioritised. In Cellular Pathology, suspected cancers were dealt with first and the samples were on red slides for ease of identification.
- Urgent abnormal blood results were phoned through to clinics to speed up patient waiting times.
- There was a one-stop-shop for breast tissue screening with results being available on the day of screening by 4PM. Patients were able to return for their results later in the day, if they wished.
- At the time of inspection, there was an influx of smear tests and we were told that this happened every year, nationally, at around the same time and was in response to the death of a celebrity from cervical cancer some years ago. The trust had been in touch with the CCG to seek solutions but other local hospitals were experiencing similar work influxes. Existing staff were carrying out overtime to get the work done and minimise the backlog.
- There was a central booking centre for all outpatient appointments and this was based in Rochdale. The staff worked in speciality/pathway teams with a co-ordinator tracker to track referral to treatment times (RTT) for their speciality. The teams met weekly and the pathway co-ordinator fed back any problems with RTT to the clinical teams. The process engaged with clinicians as trackers attended directorate meetings. The tracker would inform clinicians of the impact of clinic cancellations or delayed appointments.
- The trust had monthly referral to treatment (RTT) meetings and action plans were in place to improve the RTT times in a number of specialities.
- Trust policy was that only a directorate manager could cancel clinics. Where clinics needed to be cancelled at short notice, staff would try to contact patients by phone or letters would be sent by taxi. Clinic cancellations were minimal and the cause was generally that a Consultant was delayed in surgery at another site. The trust has not supplied figures on appointments cancelled by the hospital or by patients. Clinics sometimes ran late for this reason rather than being cancelled and patients were informed of the delay.
- Consultants could adjust the length of appointments to accommodate new patients and follow-up appointments so new patients spent longer with the Consultant for their initial assessment.
- Additional clinics were sometimes arranged on a Saturday to reduce any backlogs.

Outpatients and diagnostic imaging

- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average and the cancer waiting times for the trust were consistently better than the England average we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level. Work is being undertaken with the trust to clarify the current position
- The "Did Not Attend" (DNA) rate for the hospital where patients failed to turn up for appointments was 9%. This was worse than the England average of 7%. Managers were not aware of any action plans to improve this, for example, sending reminder texts to patients. Further appointment letters were sent or the patient was referred back to their GP if they failed to attend more than once.
- The trust had no mechanism to measure the number of patients waiting more than 30 minutes in clinic or the proportion of clinics that started late so we were unable to get any data on this.
- In Radiology, to reduce reporting times, CT scans were outsourced to Reporting radiographers in Australia overnight from 8PM, using a "follow the sun" model.
- The Biochemistry and Haematology service based at the hospital was a paperless service with results sent electronically. The service could tell whether results had been read and after three days they were printed out and sent to the referrer.
- We spoke to three patients in outpatient clinics, one of whom said they had been waiting for 2 hours and had experienced the same two weeks ago; one said that they had not waited for long in the clinic and their appointment had come through quite quickly. A third patient said they had visited the hospital 10 times in the last 2 months with a carer and had been seen on time. They had had a positive experience overall and although the department was busy, it did not seem to be understaffed.

Meeting people's individual needs

- The patient tracking list was clinically led. This tool measured progress on the 31/62 day cancer pathway. It was used to solve individual patient issues on the pathway e.g. Delayed tests or surgery. As part of this patient tracking meetings were attended by clinicians and consultants and were held at all four sites.
- The trust had play specialists available in paediatric outpatients from Monday to Friday 9AM to 5PM.
- Patients were given a choice of appointments at clinics where possible According to the Outpatient Manager.
- In the Patient Led assessment of the Care Environment (PLACE) assessments, the hospital scored 76.47% compliance in the Kenyon Suite and 82.76% compliance in the Renshaw Suite for treatment of persons living with dementia. so could improve on the environment for persons living with dementia. We did not see any action plans to make the necessary changes highlighted in the assessments.
- Bariatric patient beds were available in outpatient clinics and could be moved to the appropriate room as and when required.
- Some patient leaflets were available in different languages, for example, Urdu. Interpreters could be pre-booked to attend clinics with patients. . There were 107 bank interpreters and 11.98 W.T.E. substantive interpreter staff in the trust in the Ethnic Health Team. Interpreters were on-site at the hospital. At short notice, Language Line interpretation service was available. The trust did not allow interpretation by relatives. During 2015, 84 languages required interpretation.
- The interpretation service, also provide British Sign Language interpreters for deaf patients. The visually impaired could request documents in braille or large text and documents could be translated into different languages.
- There were numerous patient information leaflets available on the trust website.
- The Radiology Department included fact sheets about the type of treatment a patient was to undergo in the appointment letters. The letters were sent from the central Booking Centre at Rochdale Infirmary. There were no information leaflets available to patients within the department itself.
- The trust had a Learning Disability Service that was part of the Safeguarding Team and whose purpose was to ensure that patients with a learning disability received an excellent standard of care. The service assisted patients when they came to the hospital and ensured necessary reasonable adjustments were made for them. The team worked with Learning Disability Liaison Nurses across the trust and gave training and advice to staff so that they could give better care to patients with learning disabilities.

Outpatients and diagnostic imaging

- Videos were available on the trust website regarding what to do when you are feeling unwell. The videos were available in English, Arabic, Bengali, Punjabi and Urdu. The languages were reflective of the local population
- The NHS Choices website holds up to date information on referral to treatment (RTT) times for some, but not all, department in outpatients and diagnostics, details the type of clinics held in each department, and enables patients to make an informed choice about their care and treatment.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible. Patients were initially directed to the Patient Advice and Liaison Service (PALS). PALS leaflets were available in departments.
- The trust had recently ensured that PALS were more "customer facing" with desks within each hospital.
- The trust had recently reviewed their Complaints Policy and introduced clear guidelines on expected response times. Complaints were graded on severity and were to be investigated accordingly. We have however, seen instances where complaints were not responded to within the expected timelines and there appeared to be a need to embed the recent policy, clear complaint backlogs and fill staffing vacancies on the Complaints Team. The trust had action plans in place to improve the service.
- Complaints were an agenda item on the monthly directorate meetings and details were fed down to operational managers for feedback to staff.
- Staff were sometimes asked to reflect where mistakes had been made according to the Outpatient Manager. We did not see any examples of staff reflections.

Are outpatient and diagnostic imaging services well-led?

Good

We rated outpatients and diagnostic imaging services **Good** for Well-led:

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

However:

- There had been no Clinical Director in Pathology Services since October 2015. The Clinical Lead in Cellular pathology had also left and the service manager had no one to report to at the time of inspection. Recruitment for the posts was underway.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Quality and performance were monitored in outpatients through a dashboard. This covered data such as sickness rates, new complaints, RTT rates, bed occupancy figures and additional information, such as appointment cancellations and DNA (did not attend) rates.
- The Outpatients, radiology and Pathology Departments were part of the Support Services Division. The Director of the Division chaired monthly meetings about the governance of the services. The meetings also covered targets for all services within the directorate. Action plans were put in place where services were not achieving targets.
- Departmental managers met monthly about operational issues; team meetings were held every second week in outpatients.
- Consultants met monthly and held audit meetings with the interim Medical Director to discuss clinical audits and outcomes
- A trust cancer performance meeting had made 35 improvement recommendations. There was an action plan and timely resolution of all the recommendations.
- There was a Radiation Safety Group who met every three months. Agenda items included equipment, radiation incidents, dose audits for radiologists and radiographers. They produced an annual report.
- There was a departmental risk register for radiology and outpatient services. The registers contained actions and target dates for the management or resolution of the risk. The Divisional Quality and Performance Committee was responsible for reviewing the risk register
- Clinical governance meetings were attended by Nurses of band 7 and above.

Leadership of service

- There had been no Clinical Director in Pathology Services since October 2015. The Clinical Lead in Cellular pathology had also left and the service manager had no one to report to at the time of inspection. Recruitment for the posts was underway. There was no adequate escalation or oversight process in place as a result of this.
- The manager of the Microbiology Labs reported that the Trust Board were very approachable and visible.
- The CT Lead in radiology told us that they liked the Chief Executive who was very visible in the trust and had organised staff workshops to encourage ideas for improvement.
- A Health Care Assistant in Outpatients who had worked at the trust for a long time told us that there was good local leadership, they felt well-supported and had good relationships with the Consultants.
- The Outpatients Manager had seen the Chief Executive in the department and said that staff were encouraged to and supported to suggest improvements.

Culture within the service

- Managers reported that staff were visibly more proud to work in the trust now than they had been a few years ago. This followed the appointment of a number of new staff at executive level and increased staff engagement.
- Staff were proud of the Microbiology Service that was delivered from a state of the art facility. Staff showed concern about what would happen when "Devolution Manchester" took effect and whether they would take on more GP work and send more hospital work to the Virology Centre at another trust.
- Staff said that they felt respected and valued and thought that managers were supportive.
- Staff were aware of the Bullying and Harassment Policy and thought that the trust encouraged speaking up about concerns.
- Refresher training had been given to staff on Duty of Candour following the review of missed cancer diagnoses.
-

Public engagement

- The trust had involved the public on the vision, values and strategy for the trust. They had used crowd sourcing as a way of obtaining ideas and information from a large group of people.
- Patient suggestions were taken on board. A patient had said that they could hear a consultant talking to a patient in palliative care, as a result of which, the chairs in the waiting area had been moved away from the consultancy rooms.

Staff engagement

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

Innovation, improvement and sustainability

- The trust trained and utilised Link Nurses throughout the hospitals, including outpatients and diagnostic services. Link Nurses had specialities that they were the lead for and received more advanced training and clinical updates so they could advise and train other team members. Examples of specialist Link Nurses were such as specialists in dressings, diabetes, ANTT and dementia.
- The trust had an awards scheme to recognise quality and innovation in individual staff and teams.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must take action to ensure that patients on the critical care unit at Fairfield Hospital are managed in accordance with the national guidance and standards for critical care.
- Reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.
- Take appropriate actions to improve nursing and medical staffing levels in the emergency department.
- Take appropriate actions so that patients attending the emergency department are assessed and treated in a timely manner.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure that there is a supernumerary band 6/7 shift co-ordinator on duty 24/7.
- Ensure that there are standard protocols in place for the administration of intra-venous infusions..
- Ensure that the critical care risks on the risk register are regularly reviewed and updated with actions.
- Ensure that the existing arrangement for the servicing and repair of equipment assures them that all critical care equipment is fit for purpose.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it can introduce a critical care outreach service to patients at Fairfield Hospital.
- Consider how it can provide designated microbiology cover for the critical care unit at Fairfield Hospital.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.

For urgent and emergency services:

- Consider improving mandatory training compliance.
- Consider improving the processes for reviewing and managing key risks to the services.
- Consider improving the processes for monitoring and improving the management of sepsis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

This section is primarily information for the provider

Requirement notices

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

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