East Cheshire NHS Trust

Macclesfield District General Hospital

Quality Report

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Date of inspection visit: 9 - 12 December 2014
Date of publication: 15/05/2015

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	Good
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Macclesfield District General Hospital is part of East Cheshire NHS Trust and provides a full range of hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery in most specialties, cancer services, paediatrics, maternity care and a range of outpatient services.

East Cheshire NHS Trust serves a population catchment area of approximately 450,000. Inpatient services are provided from two hospital sites – Macclesfield District General Hospital (main site) and Congleton War Memorial Hospital (intermediate care service). Outpatient services are provided in Macclesfield District General Hospital and in community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton. In total, the trust has 376 beds.

East Cheshire NHS Trust is a non-foundation trust. NHS trusts are run slightly differently to foundation trusts. NHS foundation trusts, first introduced in April 2004, are independent legal entities and have unique governance arrangements. They are free from central government control and are no longer performance-managed by health authorities. As self-standing, self-governing organisations, NHS foundation trusts are free to determine their own future.

We carried out this inspection as part of our comprehensive inspection programme. This report also includes our findings for the minor injuries unit at Congleton War Memorial Hospital.

Overall, we rated Macclesfield District General Hospital as 'requires improvement'. We have judged the service as 'good' for caring. We found that services were provided by dedicated, caring staff. Patients were treated with dignity and respect and were provided with appropriate emotional support. However, improvements were needed to ensure that services were safe, effective, responsive to people's needs and well led.

Our key findings were as follows:

Cleanliness and infection control

- Patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- Policies for managing patients in isolation rooms were not always followed in surgical services.
- During our inspection we identified serious concerns with the storage of breast milk and the inappropriate storage of decontaminated equipment with clean equipment. We raised our concerns immediately with the trust. We reviewed the action the trust had taken as part of our unannounced inspection and were assured that the trust had taken the necessary steps to address our concerns. However, we identified other concerns in relation to infection control such as the decontamination arrangements for toys in the inpatient and outpatient areas and for cots on the special care baby unit. We also found that staff were unclear about the decontamination arrangements for a breast bump. As a result the matron for the service asked the breastfeeding team to review the process.
- Some areas of the maternity unit had signs of wear and tear which meant that they could not be cleaned. This included bare and worn wood around sinks and in the sluices. Chipped shelving in the clinical areas, offices and sluices and wooden doors and doorways with bare wood were present. The trust had recognised these areas required improvement as part of their capital improvement programme 2014/15. However, we raised these issues with the service during the inspection and no improvement programme was discussed.
- During the inspection we raised concerns regarding a damaged wall in the day case theatre. The trust took immediate action to address our concerns. We also found a shower room where the edges of the shower and around

the floor were not sealed, allowing water to get between the wall and the floor covering and mould was visible to that area and to the patient call bell cord. An infection control audit report for ward 1 showed that this had been identified in August 2014 but no remedial action had been taken. This was raised with staff and the edges were sealed by the maintenance team during the inspection.

Records

- The standard of record completion varied across the services. In emergency services, critical care and surgical services we found that medical and nursing notes were structured, legible, complete and up to date.
- However, we found gaps in the completion of records relating to medication, demographics, growth charts and individualised care plans on the children's ward. We also found evidence of the retrospective completion of records.
- There were variations in the completeness of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms across the hospital.
- Records in the outpatients department, occupational therapy, physiotherapy and orthotics department and on the children's ward were not stored securely in line with requirements.

Staffing levels

- Overall, medical treatment was delivered by sufficient numbers of skilled and committed medical staff.
- Consultant cover in critical care services was limited due to only six of the nine consultants being trained in intensive care. This meant that only 80% of patients were assessed by a consultant within 12 hours of admission to the critical care unit and the provision of two daily ward rounds was not achieved at weekends.
- A shortfall in the number of junior doctors in urgent and emergency services meant that the trust had to employ locum staff from November 2014 to February 2015 to cover shortages. The trust was also having difficulty recruiting to four additional registrar posts. In addition, there were four vacancies for junior doctors' in critical care services. Shortfalls were covered by locum, bank and agency staff.
- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- Although we found that staffing levels were adequate at the time of our inspection, there was no flexibility in numbers to cope with increased capacity and demand, or short-notice sickness and absence.
- The trust was actively recruiting nursing staff from overseas to try to improve staffing levels.
- The midwife-to-patient ratio averaged at one to 30. This was higher than the recommended number of one to 28. No recognised acuity tool was used to assess the number of midwives required. A staffing acuity guideline was in place based on Birth-rate plus. However this did not allow for the assessment to be done daily.

Mortality rates

- Our 'intelligent monitoring' report of July 2014 showed that there was no evidence of risk for summary hospital mortality level indicators or for hospital standardised mortality ratio indicators.

Incidents

- Systems were in place for reporting and managing incidents. However, these were not followed consistently across all services.
- In maternity services, there was poor understanding of the system for deciding the serious nature, or potential outcomes, of an incident or for how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared.
- Incidents were not always reported in line with trust policy in outpatients and diagnostic imaging services or in children's and young people's services, which meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in these services.

Nutrition and hydration

Summary of findings

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and by the speech and language therapy team.
- The patient records we reviewed included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Where patients were identified as being at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Children and young people were offered a choice of meals that were age appropriate and supported individual needs such as gluten-free and sugar-free. Children told us that they enjoyed the food. Parents told us that the food was good quality and there was a lot of choice, including healthy options.

Medicines management

- The systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, were not robust and in line with requirements.
- In urgent and emergency services, controlled drugs registers had not always been signed by two staff members when controlled drugs were dispensed. Also, controlled drugs that were wasted (unused) during a treatment had not been recorded since February 2014. Systems to dispose of controlled drugs were not being followed.
- In maternity services, the policy for checking stocks of controlled drugs was not followed in practice and we found medication in stock that was past its expiry date stored in an open box with other vials that were in date. This did not comply with the trust's policy 'Safe and secure handling of medicines'. We brought this incident to the trust's attention and it took immediate action to address our concerns.
- In children's and young people's services, the administration and recording of medication did not always occur in a timely manner.
- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Health and Social Care Act 2008 (Regulated Activities) Regulations 2014] and the trust needs to make improvements in these areas.

Importantly, the trust must:

- Ensure that there are robust systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, in line with requirements.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to children's and young people's services, pain relief documentation in the emergency department and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.
- Ensure that records in children's and young people's services are stored securely in line with regulatory requirements.
- Ensure that there are effective processes in place for the decontamination and storage of clean and contaminated equipment and for the monitoring of this, particularly in relation to children's and young people's services.
- Ensure that the environment within medical wards, surgical wards and maternity services is well maintained and fit for purpose so that appropriate standards of cleanliness can be maintained.
- Ensure that there are effective systems in place to identify, assess and monitor risks relating to the health, safety and welfare of people who use services and staff. This includes incident-reporting systems and risk-management processes for the maintenance of equipment.

In addition, the trust should:

Summary of findings

- Consider improving arrangements for clinical supervision to ensure that they are appropriate and support staff to carry out their responsibilities effectively, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.

In urgent and emergency services

- Ensure that the four-hour target data is recorded accurately at the minor injuries unit (MIU) at Congleton War Memorial Hospital.
- Assess all patients for pain relief as they enter the emergency department and ensure that the pain score and any administered pain relief are recorded accurately.
- Review the timeliness of access to interpreter services.
- Review the process to manage bariatric patients.
- Consider implementing a pain audit for paediatrics.

In surgical services

- Take appropriate action to ensure that there is adequate provision of suitable showering facilities for patients within the orthopaedic wards.
- Take appropriate action to ensure that all staff receive clinical mandatory training.
- Take appropriate action to improve performance relating to length of stay for general surgery patients in the hospital.
- Take appropriate action to improve compliance with national targets for 18-week referral-to-treatment time (RTT) standards.
- Consider taking action to ensure that there are appropriate management arrangements in the theatres department.

In medical care services

- The trust should ensure that mental capacity assessments are recorded appropriately and that all staff understand the requirements of the Mental Capacity Act and deprivation of liberty safeguards.
- The trust should take steps to ensure that all staff are included in lessons learned from incidents and near misses and have a full understanding of the trust's governance processes.
- Action should be taken to ensure that any chemicals are stored appropriately and that 'out of bounds' areas are secured appropriately.

In critical care

- Consider a review of services to manage patients safely over a 24-hour period.
- Consider reviewing the level of cover provided by consultants to ensure that there are twice daily rounds and that the assessment of admissions to the CCU can be achieved within the recommended 12-hour period.

In maternity and gynaecology services

- Ensure the safe storage of medical gases, disposable medical equipment and other items on the ward.
- Ensure that risks associated with the use of the birthing pool are assessed and appropriate emergency evacuation equipment is provided.
- Ensure that all staff are up to date with mandatory training.
- Ensure that there are systems for the safe management of patients during operations and in the event of emergencies. This should include joint working with the theatre staff and assurance that midwives who may be requested to assist in theatre are competent to do so.
- Take action to reduce the number of gynaecology operations cancelled at short notice.
- Ensure that the facilities for patients undergoing a termination of pregnancy provide privacy and dignity.

In children's and young people's services

Summary of findings

- Ensure that there are robust monitoring arrangements in place to make sure that areas are appropriately locked in children's and young people's services.
- Ensure that all staff are aware of arrangements for recording and accessing information relating to safeguarding in children's and young people's services. This includes obtaining assurance that consultant assent arrangements are followed in line with trust policy.
- Ensure that staff receive relevant training to support children and young people with mental health needs.
- Ensure that staff are competent and confident in the use of continuous positive airway pressure (CPAP) equipment.
- Ensure that there are monitoring and escalation procedures in place to make sure that there are enough staff with the appropriate skills in order to meet the needs of children and young people.

In end of life care

- Ensure that there are robust arrangements in place for out-of-hours consultant cover and that these arrangements are communicated clearly to all staff, particularly the specialist palliative care team (SPCT).
- Ensure that all staff receive appropriate end of life training.

In outpatients and diagnostic imaging services

- Ensure that equipment is maintained in line with the manufacturers' recommendations.
- Take action to reduce the number of clinic cancellations.

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	Good	Systems were in place for reporting and managing incidents. Patients received care in safe, clean and suitably maintained environments with the appropriate equipment. Medicines were not managed consistently in line with requirements. This was because the controlled drugs registers had not always been signed by two staff members when controlled drugs were dispensed and controlled drugs that were wasted (unused) during a treatment had not been recorded since February 2014. Systems to dispose of controlled drugs were not being followed. Patients were assessed for pain relief; however, the pain score had not always been recorded and, when a score was indicated, appropriate and regular pain relief was not always recorded as being given. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure that resource and capacity risks were managed. The ratio of junior doctors was worse than the England average and the trust was having difficulty recruiting to four additional registrar posts. Shortfalls were covered by locum, bank and agency staff. Security arrangements were in place at the emergency department at Macclesfield but there was no on-site security at the MIU. Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival at accident and emergency (A&E) between 5 January 2014 and 28 September 2014. However, we found discrepancies in the recording of waiting times at the MIU. Waiting times were recorded only from when the nurse actually saw and treated the patient to when the patient was discharged. This meant that data did not provide an accurate picture of the waiting times for this service. Overall however, this had limited impact on the trust's waiting time targets. Care and treatment provided were evidence-based and adhered to national guidance. We saw effective

Summary of findings

collaboration and communication among all members of the multidisciplinary team and services were geared to run seven days a week. Staff treated patients with dignity, compassion and respect, even while working under pressure.

The trust's vision and strategy had been cascaded to all staff, and staff were proud of the work they did. Key risks and performance data were monitored. There was clearly defined and visible leadership and staff felt able to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. The emergency department faced challenges such as patient flow and local changing needs, including an increased elderly population, but it had initiatives in place to tackle these.

Medical care **Requires improvement**

Some concerns were identified with unsecured environments and storage facilities. Although there were generally good practices with regard to infection control, some communal areas and equipment were unclean at the time of our inspection. Staff were committed and passionate about providing good care. All of the patients we spoke with were positive about their experience. The interactions we observed between staff and patients were varied, although they were mostly positive in nature. However, in some areas staff were task oriented and did not always provide a person-centred care approach.

The quality of records varied. Some essential care documentation, including observational records, was completed poorly. Evidence-based practice was used. However, some people's care plans were not effective in providing guidance to staff on how to safely provide care and treatment to meet patients' assessed needs. Care plans for people living with dementia were not effective. Pain relief and nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There were some measures of patient outcomes, but not all staff were fully aware of these.

Summary of findings

Staffing levels met the needs of the patients at the time of our inspection. The service was addressing concerns regarding staffing levels and staff skill mix. Staff recruitment was in progress to fill staff vacancies. Staff uptake of mandatory training was meeting the trust's target. Multidisciplinary team working was well established. Staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Staff generally felt supported and valued. Staff views on the trust's leadership and vision were varied. Services were well led at a local level in some areas but not all staff had a clear understanding of the trust's vision. In some areas, staff felt they were not engaged in decision making about their service and that there were no effective two-way communication streams.

Surgery **Requires improvement**

Older equipment, such as operating tables used in theatres, was not replaced in line with manufacturers' recommendations. During our inspection we raised this issue with the trust. We reviewed what action the trust had taken during our unannounced visit and found that it had taken action to address our concerns. The general environment within the day case and main operating theatres was not maintained suitably. We raised concerns regarding specific environmental issues during the inspection. The trust took immediate action to address our concerns. Staff received mandatory training. However, clinical mandatory training compliance was below the hospital's target of 80%. Medicines were stored safely and given to patients in a timely manner. Where patients received oxygen treatment, the use of oxygen was not always recorded on medication charts. The majority of staff followed infection prevention and control guidelines but policies for managing patients in isolation rooms were not always followed.

Patients experienced delayed transfers of care to other providers, such as community intermediate care. The surgical services had clear plans in place for how they would reduce delayed transfers of care. The hip fracture audit for 2013 showed that the hospital's performance was worse than the

Summary of findings

England average for the percentage of patients undergoing hip surgery within 36 hours and within 48 hours. The clinical director for orthopaedics told us that they had increased the number of patients with hip fractures who underwent surgery within 36 hours over the past year and the improved performance would be reflected in the hip fracture audit data for 2014. The surgical services met the national targets for 18-week referral-to-treatment times (RTT) for patients admitted for general surgery but following a national amnesty agreed by NHS England and the Trust Development Authority, failed to meet the national targets for all other specialties. The theatres department did not always meet its own performance targets, which meant that theatre lists did not always start or finish at the required times. All patients whose operation was cancelled were treated within 28 days. The average length of stay for elective and non-elective patients across all specialties was longer than the England average. The surgical services had taken action to improve the length of stay for patients undergoing elective hip and knee surgery by using rapid recovery care pathways.

There were action plans in place to address identified risks. However, we found that when issues were identified, timely action was not always taken to address those risks. The theatres department had not had a theatre manager since December 2013. The theatres were managed by two theatre leads who were band 7 nurses. The theatre leads reported to the head of service for surgical specialties and were responsible for the day-to-day management of the theatres department.

The majority of staff were positive about the culture and support available across the surgical services. Patient safety was monitored and incidents were investigated to assist learning and to improve care. The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. Patients received care and treatment by trained, competent staff who worked well as part of a

Summary of findings

multidisciplinary team (MDT). Patients spoke positively about their care and treatment. Patients were treated with dignity and received compassionate care.

Critical care

Good

The introduction of the National Early Warning Score (NEWS), a system used to determine whether or not a patient's condition was deteriorating, had been effective and audits had shown a marked improvement in the recording and use of observations. However, the outreach service that provided support for the management of deteriorating patients on the wards was limited to weekdays only with no out-of-hours or weekend support provided. Consultant cover was limited due to only six of the nine consultants being trained in intensive care. Also, there was a reliance on locum cover for junior doctors' vacancies. Only 80% of patients were assessed by a consultant within 12 hours of admission to the CCU and the provision of two daily ward rounds was not achieved at weekends.

Care was delivered in the CCU by a well-led team of competent nursing staff and in accordance with national and best practice guidance, for example National Institute for Health and Care Excellence (NICE) guidance. The service was effective at monitoring, managing and improving patient outcomes. Patients and relatives spoke positively about the care they had received and the kindness and efficiency of the staff. Staff were responsive to patient feedback and used information to improve the quality of the service.

There were reliable and effective systems in place, including for reporting and learning from incidents. Infection prevention and control measures, including hand washing and the use of personal protective equipment, were practised well and the unit was found to be clean and well maintained. There were reliable planned maintenance systems in place to ensure that equipment was available for use and fit for purpose.

Maternity and gynaecology

Requires improvement

There had been an emphasis on completing the necessary audits and training to obtain and maintain level three in the Clinical Negligence

Scheme for Trusts (CNST). This recognises a high standard of training and care. However, the standard of some of the more basic day-to-day practices and procedures, which were not included in this work, had not been maintained. Staff did not always follow procedures correctly for the management of controlled drugs or for the completion of some records. There was no formal system for deciding the serious nature, or potential outcomes, of an incident or for how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared. Some of the facilities, such as those for parents of babies in the neonatal unit and to facilitate infant feeding, were not fit for purpose.

There were no inpatient beds used specifically for patients undergoing a gynaecology operation or termination of pregnancy. Such patients could be accommodated in a mixed ward but this did not protect their dignity or the potentially sensitive nature of the support they would need. A high number of gynaecology operations were cancelled at short notice. There was no clear vision or strategy to improve or develop gynaecology services within the hospital. The trust provided information regarding the strategy for gynaecology services but staff within the service were unaware of both the strategy and any of the development plans in place. There was a lack of monitoring of day-to-day procedures and this had led to poor practice not being identified or rectified. Not all areas of risk had appropriate assessments in place or actions to reduce those risks. The trust had identified the need to plan to sustain maternity services and had identified several actions. However, senior midwifery staff did not identify these plans when we spoke with them.

The maternity services used local and national data and good practice guidance to develop policies and procedures. The working procedures and outcomes were audited to monitor the effectiveness of the service. Action plans were in place to improve outcomes in the areas identified as being below either national standards or the trust's own targets,

Summary of findings

including for the number of normal deliveries and third and fourth degree tears. There was a multidisciplinary approach to the care and support of patients, with the inclusion of specialists from other medical areas such as diabetes management and mental health services. However, there was a lack of joint working with theatre staff. The competence of staff was monitored and midwives received the necessary supervision and support. Staff were caring and treated people with respect and dignity. People spoke highly of the care they had received and the attitude of staff. There were opportunities for staff to develop personally and professionally, with clear lines of leadership and accountability in the service.

Services for children and young people

Requires improvement

During our inspection we identified serious concerns with the storage of breast milk and the inappropriate storage of contaminated equipment with clean equipment. We raised our concerns immediately with the trust. We reviewed the action the trust had taken as part of our unannounced inspection and were assured that the trust had taken the necessary steps to address our concerns. However, we identified other concerns in relation to infection control; these included the decontamination arrangements for toys in the inpatient and outpatient areas and cots on the special care baby unit. We also found that staff were unclear about the decontamination arrangements for a breast bump. As a result the matron for the service asked the breastfeeding team to review the process. We found that patient notes were not stored appropriately in the outpatient setting. We also found gaps in clinical records relating to medication, demographics, growth charts and individualised care plans.

The environment and layout in the children's ward were such that some parts of the unit were unobservable. There was no evidence of risk assessment when placing children and young people in these areas. We were also not satisfied that monitoring arrangements relating to escalation processes, staffing levels and patient acuity were robust. We raised our concerns with the

trust at the time of the inspection. We returned to the ward as part of our unannounced visit and were satisfied that new procedures had been put in place to address our concerns.

We found that, while there were ongoing discussions regarding healthcare provision, there was no clear vision or strategy in place for children's and young people's services. Staff were passionate about continually improving children's and young people's services.

Audits and monitoring of areas such as medical records and infection control had not identified the concerns we raised during our inspection. Staff knew how to report incidents but some staff told us they did not always report incidents using the electronic reporting system. For example, when levels of care changed on the ward.

Parents and young people told us that they felt safe, informed and supported by trust staff. Throughout our inspection we saw children and young people being treated with dignity and respect. We observed staff providing compassionate care.

End of life care — **Requires improvement**

Consultant and specialist palliative care services were available but lacked clear lines of communication between them. There was a committed specialist palliative care team but end of life care services lacked organisational structure and leadership. The palliative care service was limited to weekdays only with only informal consultant cover provided during periods of absence. Staff had not received any training for end of life care in the past six months due to staff shortages. There were variations in the completeness of DNA CPR forms across the hospital. Forms were supposed to be reviewed daily but evidence suggested that this did not happen consistently. Action plans had been developed in response to the National Care of the Dying Audit of Hospitals (NCDAH) but their implementation was only partially completed at the time of the inspection. There was evidence of good multidisciplinary team working on the wards and that pain relief was managed effectively. In the

main, medicines were managed safely and administered by competent staff. However, some 'when required' (PRN) medicine such as pain relief did not have a maximum dose prescribed that could be administered within a 24-hour period. This meant that patients could potentially receive more than the recommended dose.

Most staff were aware of how to report and respond to incidents and they received feedback to ensure that they learned from incidents. Safeguarding systems were well embedded in the service. In the NCDAH for 2012/13, the trust had performed in line with or better than the England average for 14 of the 17 key performance indicators. The end of life care plan introduced in July 2014 had been developed to replace the Liverpool Care Pathway. The plan included guidance for the care team about recognising and responding to deteriorating patients to ensure that their care was timely and managed effectively and that patients' preferred priorities for care were met.

The fast-track system worked well and requests were usually fulfilled within a day. There was evidence to show that most people managed to die in their preferred place of care. Consultants commented on the timely response they received to requests for support from the palliative care consultant. Patients and relatives had confidence in the medical and nursing staff and felt that they had been involved in planning their end of life care. Staff were observed to listen and respond appropriately to patients' requests in a kind and caring manner. Patients and relatives told us that they found the staff to be kind and understanding and they spoke highly of the care and support provided.

Outpatients and diagnostic imaging

Requires improvement

Incidents were not always reported in line with trust policy, which meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in outpatients and diagnostic imaging services. Records in the outpatients department and the occupational therapy, physiotherapy and orthotics department were not stored securely, which meant that there was a risk

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of people's records and personal details being seen or removed by people in the department. Records were not always available in time for clinics; on occasion this led to the cancellation of clinics. The organisation of the outpatients departments was not always responsive to patients' needs. The trust recognised that the layout and size of the department was insufficient to provide a safe environment for the number of people using the unit. However, there were no action plans or procedures that had been put in place to mitigate risk or to change the environment. Equipment had not been maintained in line with manufacturers' recommendations. Nearly a third of clinics were cancelled and patients experienced delays when waiting for their appointments. The vision and strategy for outpatients and diagnostic imaging services were not clear. Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively.

Cancer waiting times were consistently better than the England average for 31-day and 62-day targets. Since September 2013, RTT for patients with incomplete pathways were better than the England average. RTT for non-admitted patients had been inconsistent between April 2013 and May 2014 but were better than the England average from June 2014. Diagnostic waiting times had been better than the England average since November 2013.

There was evidence of good multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. We found that staff were approachable, welcoming and friendly. Staff were discreet and kind when they saw that a person was upset, and we saw them take extra time to communicate with people if they deemed it necessary.

Requires improvement

Macclesfield District General Hospital

Detailed findings

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

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Detailed findings

Background to Macclesfield District General Hospital

Macclesfield District General Hospital is part of East Cheshire NHS Trust and provides a full range of hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery in most specialties, cancer services, paediatrics, maternity care and a range of outpatient services.

East Cheshire NHS Trust serves a population catchment area of approximately 450,000. Inpatient services are provided from two hospital sites – Macclesfield District General Hospital (main site) and Congleton War Memorial Hospital (intermediate care service). Outpatient services are provided in Macclesfield District General Hospital and in community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton. The community health services include district nursing, health visiting, intermediate care, occupational and physiotherapy, community dental services, speech and language therapy and palliative care. In total, the trust has 376 beds.

East Cheshire NHS Trust is a non-foundation trust. NHS trusts are run slightly differently to foundation trusts. NHS foundation trusts, first introduced in April 2004, are independent legal entities and have unique governance arrangements. They are free from central government control and are no longer performance-managed by health authorities. As self-standing, self-governing organisations, NHS foundation trusts are free to determine their own future.

We carried out this inspection as part of our comprehensive inspection programme. This report also includes our findings for the minor injuries unit at Congleton War Memorial Hospital.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd: Bradford Hospitals NHS Foundation Trust - providing support, advice and guidance to the Medical Director's Office.

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: seven CQC inspectors; a head of governance; an NHS foundation trust executive director; a designated nurse for safeguarding children; a physician; a consultant in palliative care; a physiotherapist and outpatients locum specialist; a community paediatric physiotherapist and independent leadership consultant/mentor; a managing director; a consultant colorectal surgeon and medical director; a clinical director for women's services; a director of a school of community paediatrics and consultant paediatrician; a NHS leadership clinical fellow (previously an ST3 in the operative management of trauma); a nurse practitioner; a director of nursing in palliative care; a senior nurse and matron in theatres and a day care unit (band 8a); an emergency care technician and clinical supervisor; an expert by experience in outpatients and paediatrics; a matron in midwifery; a nurse consultant in critical care; and a senior manager in paediatrics and child health, paediatrics, community services and sexual health.

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?

Detailed findings

Before visiting, we reviewed a range of information we held about East Cheshire NHS Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

We held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of Macclesfield District General Hospital and other services provided by East Cheshire NHS Trust. Some people also shared their experiences by email or telephone.

The announced inspection of Macclesfield District General Hospital took place on 10, 11 and 12 December 2014. We also carried out an announced inspection at Congleton War Memorial Hospital on 11 December 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We undertook an unannounced inspection between 6am and 12.30pm on 22 December 2014 at Macclesfield District General Hospital only. During the unannounced inspection we looked at the management of medicines and checked to see what actions the trust had taken to address concerns we raised during the announced inspection in relation to children's and young people's services and surgical services.

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

Facts and data about Macclesfield District General Hospital

Macclesfield District General Hospital is part of East Cheshire NHS Trust and provides a full range of hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery in most specialties, cancer services, paediatrics, maternity care and a range of outpatients services.

East Cheshire NHS Trust serves a population catchment area of approximately 450,000. In total, the trust has 376 beds. In 2014, there were 36,839 admissions, 208,385 outpatients, 54,029 emergency department attendances and 5,415 attendances at the MIU based at Congleton War Memorial Hospital. The trust employs 3,200 members of staff. In 2013/14 the trust had a total income of £180,070 million.

Life expectancy for both men and women living in Cheshire East is better than the England average. However, local health profiles show that Cheshire East has three indicators for children and young people that are worse than expected: for smoking in pregnancy, starting breastfeeding and alcohol-specific hospital stays for those under 18 years old.

Road injuries and deaths are also worse than expected in the Cheshire East area.

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	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

<Notes here>

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites that formed part of East Cheshire NHS Trust. The emergency department at Macclesfield District General Hospital (MDGH) was open 24 hours a day, seven days a week, providing emergency care and treatment to people across East Cheshire. The department treated people with serious and life-threatening emergencies as well as those with illnesses or injuries that were not life threatening but still needed prompt treatment, such as minor head injuries or suspected broken bones.

The minor injuries unit (MIU) at Congleton War Memorial Hospital was a nurse-led unit seeing a variety of patients with various illnesses and minor injuries and some GP referrals. It was open from 10am to 6pm Monday to Friday and from 8am to 8pm at weekends. The MIU also saw out-of-hours GP patients between 11am and 3pm at weekends.

MDGH emergency department saw 48,000 patients from December 2013 to November 2014, of which 10,000 were children; the MIU saw 5,500 patients, of which approximately 1,000 were children.

The emergency department at MDGH consisted of a reception area with a triage room for patients who self-presented. Patients conveyed by ambulance went to the ambulance triage area, which consisted of three trollies and a seating area for up to three patients.

There were two waiting areas, one for adults and one for children. There were four bays in the resuscitation area (one designated for children). There were nine bays in the major injuries area with two rooms designated for paediatrics with access to the paediatric waiting room. The MIU at Congleton War Memorial Hospital consisted of two treatment rooms and a waiting area; there were no separate designated areas for children.

Urgent and emergency services

Summary of findings

Systems were in place for reporting and managing incidents. Patients received care in safe, clean and suitably maintained environments with the appropriate equipment. Medicines were not managed consistently in line with requirements. This was because the controlled drugs registers had not always been signed by two staff members when controlled drugs were dispensed and controlled drugs that were wasted (unused) during a treatment had not been recorded since February 2014. Systems to dispose of controlled drugs were not being followed

Patients were assessed for pain relief; however, the pain score had not always been recorded and, when a score was indicated, appropriate and regular pain relief was not always recorded as being given. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure that resource and capacity risks were managed. The ratio of junior doctors was worse than the England average and the trust was having difficulty recruiting to four additional registrar posts. Shortfalls were covered by locum, bank and agency staff. Security arrangements were in place at the emergency department at Macclesfield but there was no on-site security at the MIU.

Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival at accident and emergency (A&E) between 5 January 2014 and 28 September 2014. However, we also found discrepancies in the recording of waiting times at the MIU. Waiting times were recorded only from when the nurse actually saw and treated the patient to when the patient was discharged. This meant that data did not provide an accurate picture of the waiting times for this service. Overall however, this had limited impact on the trust's waiting time targets.

Care and treatment provided were evidence-based and adhered to national guidance. We saw effective collaboration and communication among all members of the multidisciplinary team (MDT) and services were geared to run seven days a week. Staff treated patients with dignity, compassion and respect, even while working under pressure.

The trust's vision and strategy had been cascaded to all staff, and staff were proud of the work they did. Key risks and performance data were monitored. There was clearly defined and visible leadership and staff felt able to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. The emergency department faced challenges such as patient flow and local changing needs, including an increased elderly population, but it had initiatives in place to tackle these.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Medicines were not managed consistently in line with requirements. This was because the controlled drugs registers had not always been signed by two staff members when controlled drugs were dispensed and controlled drugs that were wasted (unused) during a treatment had not been recorded since February 2014. Systems to dispose of controlled drugs were not being followed.

Records were not always completed fully. Pain scores had not always been recorded and, when a score was indicated, appropriate and regular pain relief was not always recorded as being given. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure that resource and capacity risks were managed. The ratio of junior doctors was worse than the England average and the trust was having difficulty recruiting to four additional registrar posts. Shortfalls were covered by locum, bank and agency staff. There were efficient and well-managed processes in place for handovers. There was an up-to-date trust major incident plan that listed key risks that could affect the provision of care and treatment. Security arrangements were in place at Macclesfield but there was no on-site security at the MIU.

Systems were in place for reporting and managing incidents. They aspired to a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments with the appropriate equipment. Staff were aware of the safeguarding policy and obtained consent from patients appropriately.

Incidents

- A policy was in place for the management and investigation of incidents, complaints and claims.
- Medical and nursing staff were confident about reporting incidents, near misses and poor practice in line with the trust policy via the electronic incident-reporting system.
- Data for 2013/14 showed that there had been two incidents reported via the Strategic Executive Information System (STEIS), both relating to delayed diagnosis. A total of 16 incidents were reported in the emergency department (including the MIU) from 28 November 2014 to 12 December 2014, of which the majority were rated as low risk.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of investigations to prevent recurrence. We saw that all members of the MDT were involved in incident investigations.
- We reviewed a number of incidents; these related to patients abusing staff, missing records and a patient who was admitted with a grade four pressure sore. One incident had involved a patient who was refusing to leave and was disruptive and abusive to staff. The investigation showed that security staff and the police were present and ensured that no harm was caused to the patient or to staff. This risk had been added to the local risk register; this was reviewed routinely and there was a policy for dealing with aggressive and abusive patients.
- Learning from incidents was shared across the department via noticeboards and handovers and during meetings.

Cleanliness, infection control and hygiene

- Both departments were clean, well maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as:
  - staff following hand hygiene and 'bare below the elbow' guidance
  - staff wearing personal protective equipment, such as gloves and aprons, while delivering care
  - suitable arrangements for the handling, storage and disposal of clinical waste, including sharps
  - cleaning schedules in place and displayed throughout the department areas
  - clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment
  - hand-washing facilities and hand gel available throughout the department areas.
- Data showed that rates of the healthcare associated infections methicillin-resistant Staphylococcus aureus

(MRSA) and Clostridium difficile (C. difficile) for the trust were within expected limits. Data showed that there were no cases of MRSA or C. difficile attributed to urgent and emergency care services since April 2014.
- The electronic patient administration system highlighted patients with infections to staff to allow early identification.
- All patients admitted to a ward area from A&E were screened for MRSA.

Environment and equipment

- Both the A&E and the MIU were well maintained, safe and secure.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- The route for patients was streamlined and well laid out. The emergency department was set up so that patients conveyed by ambulance and those at high risk were seen and triaged immediately.
- Patients deemed at being at high risk of events such as falls were visible from the nursing stations for continual observation and quick intervention if required.
- There was a specific x-ray service situated in close proximity to the emergency department for easy accessibility. X-ray services were available at the MIU from 9am to 5pm Monday to Friday only. If patients attended after 5pm they had to wait until the next day, and if patients presented at the weekend they had to wait until Monday morning or, in urgent cases, go to MDGH.
- The radiologist at the MIU told us that if they spotted a positive fracture they had access to 'The Red Dot' service that expedited the reporting via Macclesfield.
- A secure room was available to assess patients with mental health problems. This room complied with Section 136 requirements (a designated place of safety) under the Mental Health Act 1983.
- The resuscitation room had four bays designated for trauma that were all well equipped for adult and paediatric patients.
- Adequate equipment was available in all areas, including appropriate equipment for children and equipment for specific procedures that might be carried out only a few times a year. Staff confirmed that all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Equipment was checked and decontaminated regularly. There were checklists in place for daily, weekly and monthly monitoring of equipment such as the resuscitation trolleys.
- Staff were aware of alerts that had been issued by the National Patient Safety Agency (NPSA) and warnings had been shared with staff, for example about potential equipment sabotage.

Medicines

- Policies were available for the management of medication and posters were displayed reminding staff to check protocols if changes were made to regular medication.
- At the MIU, medication was stored safely and there were no controlled drugs on site. The emergency nurse practitioner (ENP) identified any patients who could need pain relief, and this was given immediately via a patient group direction (PGD) (an agreed medication provided on a patient-specific basis where this offers an advantage for patient care without compromising safety).
- The emergency department was equipped with an electronic dispensing module that could dispense in single doses or complete packs. Medication was stored safely and there was a comprehensive audit trail of who had accessed the medication.
- When issuing medication, the system adjusted stock levels automatically and when minimum or critical stock levels were reached the module automatically transmitted orders to the pharmacy department, which was responsible for maintaining it.
- Medicines throughout the emergency department were stored safely in locked cupboards or fridges and temperatures were recorded where necessary.
- We checked the storage and balance of controlled drugs and found that the stock balance was correct. However, we found that the controlled drugs registers had not always been signed by two staff members when controlled drugs were dispensed. We also found that the amount of morphine sulphate had been incorrectly entered as 100mg/ml in the register since February 2014, whereas it should have been 10mg/ml.
- Controlled drugs that were wasted (unused) during a treatment were not being recorded and had not been recorded in the current register since February 2014.

- Systems for the disposal and destruction of unused controlled drugs were not being followed by all staff. We brought this to the attention of the trust during our inspection and they assured us that action would be taken to address the issue.
- A ward medicines storage check was conducted on 4 November 2014 and showed that medicines were stored safely. Quarterly controlled drugs audits were conducted but had not picked up the issues we highlighted and there was no evidence of actions being assigned to appropriate staff or being followed up.

Records

- The emergency department had developed its own patient clinical assessment record that included the patient's personal details, previous admissions, alerts for allergies and observation charts, as well as triggers for chest pain and asthma.
- Patient records were kept securely and were easy to locate.
- We looked at 16 sets of notes across the emergency department and four sets of notes at the MIU. We were able to follow and track patient care and treatment easily. Observations were well recorded; the timing of such recording depended on the acuity of the patient.
- However, we found that the initial baseline assessment for the pain score was not always recorded according to the observation trigger tool in use in the emergency department. When a score was indicated, appropriate and regular pain relief was not always recorded as being given.

Safeguarding

- Policies were in place for safeguarding vulnerable adults and children. Over 90% of all staff had received mandatory training (level one) in these areas, while 76% of staff had received level two safeguarding training. This was identified on the trust's corporate risk register and an action plan was in place to improve compliance levels.
- A safeguarding link nurse and a health visitor for children worked with specific teams to ensure that patients were not at increased risk of neglect or abuse.
- Staff confirmed that they knew who to contact if they had safeguarding concerns and were aware of the services offered.

Mandatory training

- Medical and nursing staff confirmed that they had received an induction specific to their role when they had begun work in the department.
- Staff received mandatory training in areas such as infection prevention and control, moving and handling, and safeguarding children and vulnerable adults.
- Staff within urgent and emergency care also received training in areas applicable to their role. Such training included: medicines management; resuscitation training, such as Advanced Paediatric Life Support (APLS); Trauma Nursing Core Course (TNCC); and Advanced, Immediate and Paediatric Immediate Life Support (ALS, ILS and PILS). All staff had been trained to deal with paediatric trauma.
- Junior-level doctor training from April 2014 to December 2014 included topics such as identifying errors in emergency medicine, drug interactions and discussion around major incidents.
- The trust target was for 80% of staff to have received mandatory training. The performance dashboards showed that 98% of nurses in the emergency department had completed their training but the figure was only 50% for the medical staff.
- Some training, such as dementia awareness, had a low compliance rate of 32%. However, mandatory training was delivered on a rolling programme and the matron and clinical lead told us that they were confident the trust's mandatory training compliance target would be achieved by year end (March 2015). All staff who had not completed training had been identified and line managers had been made aware of this to ensure that staff were supported appropriately to complete their training.

Assessing and responding to patient risk

- All minor injuries (self-referral) patients who presented to the emergency department themselves were booked in via the receptionist and then triaged by a nurse who asked routine questions to determine the nature of the ailment.
- Patients who were conveyed by ambulance were seen immediately by a nurse at a separate entrance.
- All patients were screened and, depending on the severity of their ailment, streamed to the appropriate route. This could be the 'see and treat' area for minor injuries or, if appropriate, the GP service, which was based in the same area.

- The GP service treated patients in the emergency department during busy times once they had been triaged and if they met the GP treatment criteria.
- The 'see and treat' area consisted of two treatment rooms and was managed by a doctor and an ENP. They felt that this made the department run smoothly and efficiently.
- Upon admission, patients at high risk were placed on care pathways to ensure that they received the right level of care.
- All patients who presented at the MIU rang a bell to alert the staff and then waited before they were seen. There was no triage process in place; the ENP performed screening and treatment of patients depending on the severity of their ailment. Some ailments could not be treated at the MIU; however, patients with severe ailments still presented here. If any patients had ailments that were serious or needed further treatment, they would be conveyed by ambulance to MDGH.
- An early warning score tool was used to identify any deterioration in a patient's condition and included clear directions for escalation.
- There was an escalation policy in place and staff were aware of the appropriate actions to take if patients suffered an acute deterioration. There was daily involvement by matrons, senior staff and coordinators to address these risks. Staff knew how to escalate key risks that could impact on patient safety, such as low staffing and bed capacity issues.
- The electronic admissions system automatically alerted staff if any patients had attended the hospital or the emergency department previously and whether they were assigned to any specialist team in the hospital, for example the oncology team, so that staff could seek appropriate care for the patient.

Nursing staffing

- Nursing staff of differing grades were assigned to each of the patient areas within the emergency department.
- The shift patterns consisted of an early (7.30am to 3.30pm), late (1pm to 9pm) and night shift (8.45pm to 7.45am) plus a twilight shift (4pm to midnight). There were eight nurses and three HCAs on the early shift, nine nurses and three HCAs on the late shift and six nurses and two HCAs on the night shift, with one nurse covering the twilight shift, which was a busy period.
- The nursing establishment was based on a recognised staffing assessment tool based on Royal College of Nursing (RCN) recommendations. The staffing was set up so that there was one nurse to every seven patients. The staffing assessment tool also took paediatric requirements into consideration.
- The service manager explained that the patient acuity levels had changed at MDGH. However, although there was an in-house tool that looked at peaks in attendances, patient acuity was not taken into account. A new tool had been identified that included patient acuity and the matron was looking to pilot this.
- The numbers of nursing staff during the inspection were adequate for the flow of patients we observed. However, there was limited scope for flexibility when the department had a surge of patients, particularly in the resuscitation area.
- The matron told us that there was a high turnover of nursing staff but there was also a stable core of staff who were experienced. Due to issues with the low number of UK applicants for nursing roles, the trust was looking to recruit staff from abroad.
- 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 organisation carried out checks to ensure that they had the right level of training in delivering emergency care.
- Domestic staff stated that weekend cover was inadequate and it impacted on the workload when they returned to a full complement of staff on Monday.
- Staffing at the MIU consisted of an ENP and an HCA. From Wednesday to Friday, the HCA worked only from 2pm to 6pm. There were nine ENPs in total who rotated between the two sites. They confirmed that there were no issues and they could cope with the number of patients who presented at the unit.

Medical staffing

- The emergency department had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care.
- Data from September 2013 showed that the ratio of consultants was 28% and middle-career doctors (e.g. senior house officers) 33% compared to the England average of 23% and 13% respectively. The ratio of registrars (39%) was the same as the England average (39%). Medical staffing consisted of seven consultants, six middle-grade doctors and five junior staff. The

deanery had provided junior doctors but only for four months and not the usual six months. This meant that the trust had to employ locum staff from November 2014 to February 2015 to cover the shortfall.

- All medical staff worked various shifts over a 24-hour period to cover rotas and to be on call out of hours and at weekends; consultants on call had to be located within 30 minutes from the hospital. On weekdays, a consultant would be available from 8am to 9pm. At weekends, the consultant cover was from 8.30am to 5.30pm. A consultant was available via the on-call rota at nights and during the weekends. There was at least one middle-career doctor and a junior staff member on duty.
- The department had funding for four additional registrars but it was proving difficult to recruit them.
- The clinical lead told us that there was a stable middle-grade and consultant-level workforce. Maintaining steady staffing was a challenge and the aim was to develop new staffing models that would be sustainable. Another positive area was that the historical division between the nursing and medical teams was narrowing, which meant closer team working.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff underwent an induction before they were allowed to work in the trust.
- There was no routine medical cover at the MIU. If any patients presented who needed immediate assistance then help would be sought from the community ward based on site at Congleton prior to transfer to MDGH.

Handovers

- Handovers took place three times daily and more frequently during times of escalation.
- Professional staff, such as nursing staff, medical staff, the mental health liaison team, the children's health visitor and the hospital alcohol liaison team attended as required.
- Handovers took place around the patient whiteboard and topics discussed included staffing levels, patient handover-related issues, clinical acuity and medication needs, as well as the trust escalation status and any breaches that had occurred.
- Senior and junior staff attended handovers to make sure that they were all aware of any tasks that were allocated, such as blood samples to be taken from patients.
- All the information was then logged in a communication file to ensure that those staff not present could also be made aware of any information.
- We observed handovers of patients from the ambulance staff to the hospital staff. These were discreet, dignified and efficient.

Major incident awareness and training

- Guidance for staff in the event of a major incident was available in the major incident plan and in the corporate business continuity plan; this listed key risks that could affect the provision of care and treatment. Data showed that 65% of staff had attended the major incident training in 2012 and 27% of staff had attended the in-house trauma study day.
- The department had decontamination facilities and equipment, such as decontamination tents, to deal with patients who might be contaminated with chemicals.
- The clinical lead for the emergency department told us that staff from the trust did not attend the scene of any major trauma and the trust was not a trauma centre. They confirmed that a large proportion of the department's work was with sick frail elderly people and people with presenting with mental health issues. The department had good links with the mental health liaison team, which also attended handovers to ensure that people received appropriate care.
- Simulation training was run by an MDT and was aimed at managing the sick patient. It was filmed and played back to assist in the training of junior doctors and nurses. However, medical and nursing staff we spoke with were unaware of this training.
- On-site security guards patrolled the car park, corridors and public areas at MDGH. Staff in the emergency department could bleep security for immediate support and would also dial 999 for police assistance if required. All staff had received conflict resolution training. There was no on-site security at the MIU. The ENP told us that there was CCTV, mobile video equipment, handheld buzzers and call bells in the treatment rooms that alerted the police if staff needed help or if they felt unsafe.

Urgent and emergency services

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

Good

Care and treatment provided were evidence-based and adhered to national guidance. The department participated in national Royal College of Emergency Medicine audits and there were clear action plans indicating what improvements needed to be made as a result. Patients were assessed for pain relief as they entered the emergency department; however, patient records showed that the pain score had not always been recorded and, when a score was given, appropriate and regular pain relief was not always recorded as being given. Patients were not offered refreshments during busy periods.

Departmental records showed that all staff had received appraisals. We saw effective collaboration and communication among all members of the MDT and services were geared to run seven days a week. Information for patients was accessible and appropriate arrangements were in place to gain consent.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided.
- A range of clinical care pathways had been developed and audited for compliance in accordance with recognised guidance, for example in areas such as acute kidney injury, alcohol misuse, paracetamol overdose and fractured neck of femur.
- These pathways were put into action as soon as the patient entered the department, which meant that patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results reviewed promptly.
- The patient assessment record reflected evidence-based guidance for effective risk assessment and included tools for assessing patient risks such as sepsis. This meant that, if the patient's condition deteriorated, medical staff could be alerted quickly.
- Guidance was discussed regularly at meetings and the impact any changes would have on staff practice was also discussed. Staff were encouraged to undertake a clinical audit to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care.
- An audit in May 2014 using NICE guidelines to look at reducing the risk of venous thromboembolism (VTE) had resulted in the introduction of a one-page protocol for staff to follow to ensure that the guidance was followed.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A streaming process identified any patients who could need pain relief, which was given immediately via a PGD.
- The department had participated in the national RCEM audit for renal colic in 2012 that assessed the expedience of pain relief. The audit showed that 100% of patients had received analgesia in accordance with local or national guidelines and 100% of patients were offered this within one hour.
- Seven out of the 15 patient records we reviewed in MDGH's emergency department showed that the pain score had not always been recorded and, when a score was given, appropriate and regular pain relief was not always recorded as being given. Patients we spoke with reported that they had been offered appropriate pain relief. The senior nurses conducted audits of pain scores and had also found similar issues. A senior sister matron told us that this was an error due to particular staff and it would be investigated.
- The trust reported that there was no evidenced documentation of pain audits for paediatrics.

Nutrition and hydration

- The department had facilities to make hot drinks and snacks such as toast and cereal. There was a fridge with sandwiches for patients and staff told us that they could get food from the hospital kitchen if required and that warm meals could be provided if requested.
- There was no designated staff member on each shift responsible for offering drinks or food to patients in the department.

- We saw patients being offered refreshments on an ad hoc basis during our visit. We observed one elderly patient who still had toast on their table at lunchtime when it had been offered at breakfast time.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national RCEM audits so that it could benchmark its practice and performance against best practice and other A&E departments. Audits included consultant sign-off, renal colic, vital signs in majors and fractured neck of femur.
- Data from the 2013 RCEM audits for consultant sign-off showed that 19% of patients' diagnosis had been discussed at consultant level (better than the England average of 12%) and 19% at senior doctor level (worse than the England average of 31%). RCEM standards are that 100% of these discharged patients need to be discussed with a consultant at the very least.
- Data showed that the trust was performing poorly in relation to the RCEM 'vital signs in majors' audit for 2011. The trust compliance was poor compared with other trusts for 'Were these vital signs measured and recoded after arrival/triage?' and for 'If vital signs were abnormal, were observations repeated and recorded in the notes?' The trust achieved 53% for 'Were appropriate investigations carried out and the results recorded in the notes before discharge?' and compliance was only 13% for the question 'Is there evidence in the notes that abnormal vital signs were communicated to the nurse in charge?' A local action plan was in place to improve compliance with these outcomes.
- Unplanned re-admittance rates to the emergency department within seven days from January 2013 to May 2014 were above the 5% target set by the Department of Health and was comparable with the England average for the same timeframe.

Competent staff

- Departmental records showed that 64% of medical staff, 77% of nursing staff and 100% of administration staff in the emergency department had received appraisals for the year 2013/14. Staff we spoke with reported that they had received an appraisal within the last year. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Information provided by the trust identified that the process for 2014/15 had started and was ongoing. We saw the schedule in place for staff to see their managers. The current status as of August 2014 was that 69% of medical staff, 93% of nursing staff and 94% of administration staff had received an appraisal.
- The nursing and medical staff were positive about on-the-job learning and development opportunities. Medical staff told us that clinical supervision and revalidation were in place and were non-hierarchical.

Multidisciplinary working

- We observed collaboration and communication among all members of the MDT to support the planning and delivery of patient-centred care.
- Daily meetings, involving the medical staff, nursing staff and therapists as well as social workers and safeguarding leads where required, ensured that the patient's needs were fully explored. This included identification of the patient's existing care needs, relevant social or family issues and mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.
- The hospital alcohol liaison team (HALT) was managed externally by another local trust. A support worker led a team of volunteers to support patients with alcohol dependency. They were available from 9am to 5pm Monday to Friday and provided an open drop-in session every Friday morning for patients to talk openly with their peers.
- The mental health liaison team provided support to patients with psychiatric issues and worked with staff in the emergency department from 9am to 5pm and between 8.30pm and 9am on weekdays. A consultant liaison psychiatrist and nurse practitioner covered the role. The team aimed to see patients within an hour and had their own pathways, management plans and confidential systems in place.
- Evidence of good partnership working with the local ambulance service was discussed whereby ambulance staff worked with the trust and GPs in the area to reduce traffic into A&E.

Seven-day services

- Staff rotas showed that staff levels were sufficiently maintained out of hours and at weekends.
- The x-ray department at MDGH was open 24 hours a day, seven days a week. There was limited access to specialist investigations such as MRI and computerised

tomography (CT) scans and to a radiologist to interpret scans out of hours but an on-call radiologist was available. A local agreement was in place whereby senior staff were able to interpret certain scans out of hours so that treatment or admission was not delayed.
- X-ray services were available at the MIU from 9am until 5pm Monday to Friday only. If patients attended after 5pm they had to wait until the next day, and if patients presented at the weekend they had to wait until Monday morning or, in urgent cases, go to MDGH.
- Pharmacy services were available seven days a week with limited hours at weekends from 10am till 1pm. During working hours, patients attending the emergency department who required medication were directed to the hospital pharmacy. The departments held a stock of frequently used medicines such as antibiotics and painkillers that staff could access out of hours. Stock levels were appropriate and were checked regularly to ensure that the supply was adequate for peak times such as weekends and public holidays.

Access to information

- Patients confirmed that they had received information in relation to their care and treatment in a manner they understood.
- Information relating to patient safety was displayed on noticeboards in the areas we inspected.
- Staff could access information such as audit results, lessons learned from incidents, performance indicators and updates to policies via the staffroom and we saw that clinical pathways, policies and procedures were accessible on the intranet.
- The department used an electronic system to track when patients were admitted to the department and found the system to be very useful as it linked with the other departments and ward areas. This meant that it showed real-time patient movement.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff told us that they mostly sought verbal and implied informed consent due to the nature of the patients attending the department. Written consent was sought before providing care or treatment such as anaesthetics or at the MIU.
- Arrangements were in place to ensure that staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults and children, the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS).
- Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead.
- 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

Staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious.

The Friends and Family Test scores were positive. Staff confirmed that they could access management support or counselling services if they had been involved in a traumatic or distressing event and debriefs were held following traumatic events.

Compassionate care

- All the patients, relatives and representatives we spoke with at both sites were positive about the care and treatment provided.
- We observed many examples of compassionate care. We saw the ward clerk take time out to speak with patients and to reassure them. However, during busy times, we noted that there was little interaction with the patients.
- The NHS Friends and Family Test had a low response rate between April 2014 and July 2014 which meant that the results were not completely reliable. However, data showed that 87% patients would recommend the department to friends and family and 7% would not recommend the department.

Urgent and emergency services

- A review of the data from the CQC's adult inpatient survey for 2013 showed that 85% of patients felt that they were given information relating to their condition and 89% felt they were afforded sufficient privacy and dignity.

Understanding and involvement of patients and those close to them

- Upon admission to the emergency department patients were allocated a named nurse. Ambulance staff worked with the hospital staff to ensure continuity of care by making sure that all the information they had recorded about the patient was handed over.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed that their consent had been sought prior to care and treatment being delivered.
- We found that relatives and/or the patient's representatives were also consulted in discussions about the discharge-planning process. The records contained a specific section that recorded the discharge process.

Emotional support

- Staff were clear about the importance of providing patients with emotional support. We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.
- A family room was available for people who accompanied patients involved in traumatic events such as road traffic accidents.
- There was a bereavement room for deceased patients that allowed family members to spend extra time with their loved ones. A bereavement leaflet and pack were available that gave step-by-step instructions on the services available and how they could be accessed.
- Staff confirmed that they could access management support or counselling services if they had been involved in a traumatic or distressing event such as treating a patient involved in a fatal road traffic accident, or if they had had a negative experience. Nursing and medical staff told us that debriefs were held after traumatic events.
- The emergency department had cards with butterflies printed on one side. If a patient passed away, the staff would make the butterfly visible; this informed everyone of the situation and made sure they knew to be respectful.
- Bravery certificates were given to younger children who attended the emergency department to relieve their anxiety and to help them overcome their fears.

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

Good

Performance was improving across the trust. Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival at A&E between 5 January 2014 and 28 September 2014. However, we found discrepancies in the recording of waiting times at the MIU. Waiting times were recorded only from when the nurse actually saw and treated the patient to when the patient was discharged. This meant that data did not provide an accurate picture of waiting times for this service. Overall however, this had limited impact on the trust's waiting time targets.

Patient flow out of the department was a challenge and had a negative impact on waiting times within the emergency department when patients could not be moved out into ward areas. Bed occupancy within the hospital also contributed to poor performance; this was around 90% between April 2014 and September 2014. Staff felt that there was a constant pressure to move patients through the department to meet targets.

Translation services were available for patients where English was not their first language but could take over an hour to arrange. The process to manage bariatric patients was cumbersome and meant that patients could wait up to 24 hours for appropriate equipment.

Service planning and delivery to meet the needs of local people

- The trust-wide escalation policy described how the emergency department would deal with a range of foreseen and unforeseen circumstances when there was significant demand for services or if there were resource issues such as lack of staffing.
- Nursing and medical staff were familiar with this policy and were very clear about the importance of the whole hospital, and other agencies, working together.
- There was a responsive coordination of senior staff who arranged beds, investigations and scans for patients to ensure that the service could better manage patients at busy times.
- Daily bed management and safe staffing meetings took place so that capacity was monitored constantly.
- The emergency department had an appropriate designated children's waiting area. There was also a designated children's bay in the resuscitation area. In the major injuries area there were two rooms designated for paediatrics with access to the paediatric waiting room.
- The MIU consisted of a shared waiting room with the x-ray department at Congleton War Memorial Hospital, a staff office and two treatment rooms (only one was used most of the time). There were no separate waiting or treatment areas for children.
- There was no direct access to toilet facilities in the MIU at the weekend. Patients had to walk a considerable distance to use the available facilities.
- The HALT lead told us that resources were limited and they could not always provide the full service they wanted to, such as specific pathways for people with alcohol withdrawal symptoms so that they could avoid admittance to A&E.

Meeting people's individual needs

- A variety of information leaflets were available in the emergency department. These were all in English but some specific leaflets in Chinese, Bengali and Polish were kept at the reception desk.
- Staff told us that they would not use relatives or family members to assist patients with consenting procedures during treatment. Interpreter services were available via a telephone service or face to face for patients whose first language was not English. However, nursing staff told us that they would often try to find a staff member who spoke the language as it could take an hour to access a translator via phone. We saw cue cards that patients could point to for some ailments.
- A noticeboard and information leaflets outlined the various multi-faith services available with timings for specific prayers and services. The chapel was close by for people to reflect and it included a separate room with prayer facilities for different religions.
- Patients living with dementia were treated in specific cubicles to protect them and so that they were visible to staff. One cubicle door frame had been painted blue to stand out from the rest and a large clock and furniture had been ordered to make the environment more dementia-friendly. A sticker was placed on the notes so that staff knew the patient was living with dementia and could take appropriate action.
- Staff asked patients with learning disabilities if they had a completed 'passport document' with them. This was completed by the patient or their representative and included key information such as the patient's medical history and likes and dislikes.
- Where a patient was identified as living with dementia or having learning disabilities, staff could contact trust-wide specialist link nurses for advice and support.
- The process to manage bariatric patients (bariatric refers to the branch of medicine that deals with the causes, prevention and treatment of obesity) started when the patient was being conveyed. The ambulance staff would usually make this known in advance so additional staff and appropriate equipment, such as a bariatric trolley, could be provided to support the moving and handling of bariatric patients as required. We saw that the emergency department had access to its own bariatric wheelchair and trolley and access to bariatric trollies from the acute assessment unit (AAU) where required. There were no commodes or beds for bariatric patients in the department. Nursing staff told us that they would borrow these items from ward 11 when required. However, they told us that equipment was not always available and so they would have to ring an off-site company with which the trust had an agreement. This meant that it could take up to 24 hours to have appropriate equipment delivered.
- Care plans were in place in the department for children who attended frequently and who had direct access to the emergency department for recurring and ongoing conditions such as asthma.

Urgent and emergency services

Access and flow

- Overall, the trust met the national Department of Health target for emergency services to admit or discharge 95% of patients within four hours of arrival at A&E between 5 January 2014 and 28 September 2014.
- The data reported by the Department of Health was a combination of attendances at the emergency department at MDGH and at the MIU at Congleton War Memorial Hospital. Data for the emergency department at MDGH only showed that the department did not fully meet the target between 5 January 2014 and 28 September 2014, achieving 94.6% between 5 January 2014 and 30 March 2014, 94.9% between 6 April 2014 and 29 June 2014 and 94.8% between 6 July 2014 and 28 September 2014.
- Data showed that patients attending the MIU were seen very quickly and there were no breaches of the four-hour target at this site. During the week of our inspection, the MIU achieved 100% compliance daily on seeing patients in less than four hours. Many patients were seen, triaged and discharged within a matter of minutes.
- However, upon investigation, we found discrepancies in the recording of waiting times. Patient times were recorded only from when the nurse actually saw and treated the patient to when the patient was discharged. The waiting times for patients before they saw the nurse were not recorded. This was because there was no reception area or booking-in system for patients and the nurse was seeing patients. We spoke to five patients and their representatives who told us that they had waited between five and 20 minutes. We also observed patients waiting to be seen but the time was not recorded.
- The number of attendances to the emergency department was relatively constant over the previous six months in 2014: the department saw 4,189 patients in June, 4,489 patients in July, 3,953 patients in August, 4,222 patients in September, 3,991 patients in October and 3,919 patients in November. The department saw a total of 48,000 patients from December 2013 to November 2014. Of these admissions 10,000 were children.
- The number of attendances to the MIU was relatively constant over the previous six months in 2014, with the A&E seeing 497 patients in June, 524 patients in July, 441 patients in August, 557 patients in September, 480 patients in October and 395 patients in November. The department saw a total of 5,500 patients from December 2013 to November 2014. Of these admissions, 1,000 were children. Data for the MIU showed that between 10 and 25 patients attended daily.
- During the week of our inspection, there was a total of 42 breaches as the trust was in amber or red alert, which meant that it was almost at full capacity. The main reason for the four-hour breach was that patients were waiting for a bed to become available in the ward area. We saw one patient who had been in the department for 17 hours and some who had been in the department for around eight hours.
- The emergency department achieved (four hour target rate) 90.2% on 8 December 2014 with 143 attendances, 96.2% on 9 December 2014 with 113 attendances, 89.8% on 10 December 2014 with 131 attendances and 94.8% on 11 December 2014 with 121 attendances.
- All individual breaches were investigated and categorised according to why they occurred. Data showed that 2,315 breaches had occurred during the previous 12 months due to patients not being assessed in the department, not being able to be discharged due to clinical needs, or needing psychiatry input. In other weeks we saw that patients could not be discharged because they needed specialist input or were awaiting transport.
- There was no surgical assessment unit in the hospital. If a patient required any surgical input then the surgical team would assess the patient in the emergency department and determine the treatment. This had an impact on the time patients waited in the department.
- Data showed that the rate of patients leaving without being seen was better than the England average from January 2013 to May 2014 and always below the upper target of 5% set by the Department of Health.
- The target to achieve 85% of ambulance handovers within 15 minutes was mostly achieved by the department for 2013 to 2014; however, data showed that from April 2014 to September 2014 the performance was at 82%. Data showed that the number of handovers delayed over 30 minutes from November 2013 to March 2014 was 173; this was low compared with other trusts for the same period.
- The percentage of emergency admissions via the emergency department who waited between four and 12 hours from the decision to admit until being admitted was better than the England average.

Urgent and emergency services

- Referral-to-treatment times (RTT) were below the England average for similar trusts.
- Patient flow out of the department was a challenge and had a negative impact on waiting times within the emergency department when patients could not be moved out into ward areas.
- Bed occupancy within the hospital also contributed to poor performance, as it was around 90% between April 2014 and September 2014.
- Staff felt that there was a constant pressure to move patients through the department to meet targets.

Learning from complaints and concerns

- There was a trust-wide complaints policy (Listening, Responding and Learning from Views and Concerns).
- A patient leaflet included information on how to raise concerns and complaints and how to provide comments and compliments. This included contact details for the customer care team at the trust and included information about the Patient Advice and Liaison Service (PALS). However, it was available only in the waiting room area.
- Nursing, medical and administrative staff understood the process for receiving and handling complaints in the department.
- Complaints were recorded on a centralised trust-wide system. The emergency department and the MIU had received 17 complaints between October 2013 and August 2014.
- We reviewed three complaints that had been raised and found that staff had followed the correct process and timescales. Information about complaints was discussed during routine team meetings to raise staff awareness and to aid future learning.

Are urgent and emergency services well-led?

Good

The organisation's vision and strategy had been cascaded to all staff, and staff were proud of the work they did. The overall ethos was that patient care came before targets and positive care would lead to better outcomes. Key risks and performance data were monitored. There was clearly defined and visible leadership and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.

The emergency department faced challenges such as patient flow and local changing needs, including an increased elderly population, but it had initiatives in place to tackle these issues. The trust received additional financial resources to enable it to manage winter pressures; planning for this included additional resources to increase the timeliness of treatment for patients with mental health issues and to fund additional emergency nurse practitioners in the triage area.

Vision and strategy for this service

- The trust mission "to provide sustainable, safe, effective and personalised care, of which we can all be proud" and vision "to deliver the best care in the right place" were visible across the emergency department. The trust's board objectives were focused on patient services, empowering people, developing partnerships and managing resources effectively.
- The trust's vision and objectives were included in the corporate induction that all staff underwent and staff had a clear understanding of what these involved.
- The trust's priorities, outlined in the trust quality strategy and in the clinical strategy for 2012 to 2015, incorporated this vision and included specific strategic objectives for the emergency department. These included: to have improved emergency care pathways; to increase the response rate to the Friends and Family Test; and to meet the targets set out by the Department of Health, as well as having short, medium and long term plans in place to respond to the changing demands faced by the service. The update from the quality account 2013/14 stated that the response rate for the friends and family test from the emergency department had increased and plans were in place to reorganise the emergency department into the urgent care floor in order to improve patient flow.

Governance, risk management and quality measurement

- Senior staff were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators.

- The local risk register included risks that were rated for severity and progress. Improvements were monitored through regular meetings and fed back at departmental and executive level.
- Risks were rated from low to high with the lower risks being managed at ward level and the higher risks being escalated corporately.
- The clinical lead and matron felt that the local risks were the numbers of staff employed and the skill mix, with the main risk being patient flow during busy times. We looked at the local risk register and saw that these and other key risks had been identified and assessed.
- Day-to-day issues, information relating to complaints and incidents and audit results were shared on noticeboards around the department and via meetings and 'safety huddles' (safety huddles were team meetings that took place every day to identify any key risks in the department and any specific patient needs).
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles within the emergency and urgent care services; these included a clinical lead, a matron and a service manager. These leads provided visible leadership, particularly at times when the emergency department was stretched.
- The teams were motivated and worked well together with good communication between all grades of staff. Nursing and medical staff felt that their efforts were acknowledged and their managers listened and reacted to their needs.
- Staff felt able to challenge any staff members who were seen to be unsupportive in the effective running of the service.

Culture within the service

- Nursing and medical staff told us that the overall ethos was that patient care came before targets and positive care would lead to better outcomes. We saw that staff focused on providing the right treatment at the correct time.
- Staff spoke of an open culture where they could raise concerns and where those concerns would be acted upon. We observed that staff from all specialties worked well together and had mutual respect. Nursing staff told us that they could and would challenge the medical staff if they felt it was in the patient's best interest.
- Staff told us that morale within the department was good and the teams worked well together. However, at times, when the department was particularly busy, staff felt that the morale dropped.
- All staff told us that they were encouraged to report any issues in relation to patient care or any adverse incidents that occurred.

Public and staff engagement

- Information on how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the website.
- Administrative staff told us that they routinely engaged with patients and their relatives to gain feedback from them.
- Staff received communications in a variety of ways, such as newsletters, emails and briefing documents and meetings. Staff told us that they were made aware when new policies were issued and felt included in the organisation's vision.
- The clinical lead produced regular updates for the medical staff with clinical updates, alerts on issues such as recent infections and departmental information.
- Staff had completed the NHS survey. The 2013 results showed that 90% of staff felt their role made a difference to patients' lives and 72% of staff felt satisfied with the quality of work and patient care they were able to deliver. However, 18% of staff had experienced harassment, bullying or abuse from other staff in the last 12 months and 31% of staff had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. Overall, the trust results were similar to those of other trusts of the same size.
- The department included 'You said, we did' information on noticeboards that listed improvements made by the trust in response to queries raised by staff.
- A Patient Experience Survey for inpatients was conducted every three months. Not all the questions applied to the emergency department but for those that did the latest survey for July to September 2014 showed positive feedback in the following areas: 'Did ward staff

check that you were comfortable and had everything you needed (e.g. a drink, access to the call button etc.) on a regular basis?' and 'Did you have enough privacy when discussing your condition or treatment?'

Innovation, improvement and sustainability

- Medical and nursing staff told us that the main challenges were the flow of patients out of the emergency department and local changing needs, such as an increased elderly population.
- We found a number of initiatives in place to reduce patient flow into the emergency department, such as ambulatory patients being triaged in the newly opened ambulatory bay area.
- Prior to our inspection, the emergency department, the medical admissions unit and the AAU were all part of the same service line. A report was presented at the clinical management board in July 2014 to gain approval to reorganise and create an urgent care floor. Proposed benefits included improved patient experience through the creation of an ambulatory care assessment area, reduced four-hour waits and reduced overnight stays through the removal of overnight beds. Implementation had started and an update from October 2014 showed that progress had been made and the project was due to be completed in January 2015.
- The trust received additional financial resources to enable it to manage winter pressures; planning for this had begun in July 2014. The leads told us that the number of patients did not differ over this period but the type of patient and the nature of ailments did. For example, more elderly patients presented due to falls. The additional resources were going into increase the timeliness of treatment for patients with mental health issues and to fund additional emergency nurse practitioners in the triage area.

Medical care (including older people's care)

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

Information about the service

East Cheshire NHS Trust's services are organised into seven clinically led service lines, including medical specialties, which provide cardiology, stroke, dermatology, diabetes and endocrinology, gastroenterology, neurology and respiratory services. The hospital has six medical care wards including Ward 3 (a general medicine and gastroenterology ward with 28 beds), Ward 4 (a general medicine and respiratory ward with 28 beds), Ward 7 (a cardiology ward with 28 beds), Ward 8 (a medical assessment unit or MAU ward with 28 beds), Ward 11 (a general medicine and stroke ward with 24 beds), the coronary care unit (or CCU, with 12 beds), a discharge lounge and an ambulatory care unit

During our inspection, we visited all ward areas, the ambulatory care unit and the discharge lounge. We spoke with 29 patients, 48 staff, and 16 people visiting relatives. We also looked at the care plans and associated records of 24 people. We held focus groups with nursing, medical staff and ancillary staff, as well as speaking to senior doctors and nurses.

Summary of findings

Some concerns were identified with unsecured environments and storage facilities. Although there were generally good practices with regard to infection control, some communal areas and equipment were unclean at the time of our inspection. Staff were committed and passionate about providing good care. All of the patients we spoke with were positive about their experience. The interactions we observed between staff and patients were varied, although they were mostly positive in nature. However, in some areas staff were task oriented and did not always provide a person-centred care approach.

The quality of records varied. Some essential care documentation, including observational records, was completed poorly. Evidence-based practice was used. However, some people's care plans were not effective in providing guidance to staff on how to safely provide care and treatment to meet patients' assessed needs. Care plans for people living with dementia were not effective. Pain relief and nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There were some measures of patient outcomes, but not all staff were fully aware of these.

Staffing levels met the needs of the patients at the time of our inspection. The service was addressing concerns regarding staffing levels and staff skill mix. Staff recruitment was in progress to fill staff vacancies. Staff uptake of mandatory training was meeting the trust's

Medical care (including older people's care)

target. Multidisciplinary team working was well established. Staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Staff generally felt supported and valued. Staff views on the trust's leadership and vision were varied. Services were well led at a local level in some areas but not all staff had a clear understanding of the trust's vision. In some areas, staff felt they were not engaged in decision making about their service and that there were no effective two-way communication streams.

Are medical care services safe?

Requires improvement

The number of permanent nursing staff varied, and there was a reliance on bank and agency staff. Some staff said they felt pressurised due to high patient dependencies. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people. All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance. The introduction of performance boards across the wards was seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them.

Regular audits were being carried out on the main risk areas. We found variable record keeping with regard to people's observations. The systems for storing medicines were not appropriate on all wards and temperature checks of some storage rooms were not carried out. Most areas were clean but we found some potential infection control risks in the environment. The trust had a significantly higher proportion of junior doctors compared with the national average.

Incidents

- Staff were aware of the trust's policy for reporting and recording incidents and accidents. Senior staff said that there was a high level of incident reporting. Junior staff were aware of how to use the hospital's computerised system to report concerns. Performance, patient safety data and learning from incidents were generally discussed at monthly ward meetings.
- All wards displayed a performance board on which the number of incidents regarding falls, infectious diseases and newly acquired pressure ulcers was reported.
- Staff told us how incidents were recorded and reported via the trust's computerised incident-reporting system. Junior staff said that they had received training to use the electronic incident-reporting system. Some doctors told us that they rarely completed incident forms using the electronic reporting system but that junior staff and nurses completed them.

Medical care (including older people's care)

- There were systems to support shared learning from incidents across medical wards. Most staff told us that they had received feedback about the incidents reported, but some staff told us that they did not know what happened to the reported information. Learning from incidents in other ward areas was not always shared across the hospital. Staff on Ward 7 were not able to tell us what the hospital's plans were to reduce the incidence of skin damage, whereas Ward 4 was implementing an action plan to reduce these risks for patients.
- In the trust's Annual Report and Quality Account for 2013 to 2014, the trust reported more incidents (12.4) per 100 admissions than the national average of 7.7 incidents per 100 admissions. However, 98% of these incidents were 'near misses' or low harm to patients.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards. Staff in the CCU said that incidents were reviewed at their monthly team meetings and they had good feedback about incidents from their matron.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.
- Senior staff told us that morning handovers (safety briefings) included risks and incidents and that learning from these was shared at these meetings.
- Some staff were able to tell us about the ways in which people's falls were investigated, and what plans were in place to reduce the risk of further falls. We saw some evidence that movement sensors or alarm mats had been used as a potential measure to reduce the risk of falls following reviews of incidents (for example on Ward 4 and Ward 11).
- Across the medical wards for the trust, there were six serious incidents between April 2013 and March 2014 in the medical care wards out of a trust total of 13. Two were incidents of newly acquired infectious diseases.
- From July 2013 to July 2014, there were 105 incidents reported of skin damage at grade two or higher; this figure was comparable with the number of incidents at trusts of a similar size.
- From July 2013 to July 2014, there were 76 falls reported. There had been a decrease in both skin damage and falls incidents between December 2013 and April 2014, and a slight increase from April 2014 to July 2014.
- From July 2013 to July 2014, there were 56 reported incidents of catheter-acquired urinary infections, with a decreasing prevalence rate.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections (for people with catheters) and blood clots (venous thromboembolism or VTE).
- Safety Thermometer audits were carried out by each ward and looked at the instances of falls, newly acquired pressure areas, VTE assessments and urine infections for patients with a catheter.
- Senior staff told us that summary information from the monthly Safety Thermometer audit was usually shared with staff regularly via team meetings.
- Safety Thermometer information was sent to ward managers via email and was presented on the 'Know how you are doing boards' available on the trust's intranet.
- On ward 4, the staff meeting minutes did not show the Safety Thermometer as a standing agenda item but patient safety risks were discussed under incidents and ward performance information. Three out of four staff members we spoke to were aware of the Safety Thermometer audits but were unclear about what learning had been implemented from these audits for their ward.
- The incidence and timing of falls were being monitored on some wards.
- Not all staff with whom we spoke were able to explain clearly what actions were being taken to prevent pressure ulcer development.

Cleanliness, infection control and hygiene

- Most wards and communal areas were visibly clean and odour-free. Personal protective equipment (PPE) was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.

- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate that barrier nursing was in place. Ward 7 had two side rooms that had en suite toilets that could be used for isolation purposes.
- Generally, cleaning schedules had been completed as required. Housekeeping staff told us that there were sufficient supplies of cleaning materials available for their use. Cleaning storerooms were generally clean and tidy and we noted that Control of Substances Hazardous to Health (COSHH) information sheets for cleaning materials were available for staff.
- When we carried out observations, we saw that staff followed universal infection control procedures in most instances. Nursing staff and doctors generally used hand-sanitising gels at patients' bedsides before and after seeing patients.
- Green 'I am clean' stickers were used to show that equipment had been cleaned and was ready for use.
- Ward performance boards showed incidences of infectious diseases in the previous month. For example, Ward 7 had had no new cases of Clostridium difficile (C. difficile) or methicillin-resistant Staphylococcus aureus (MRSA) for November 2014. Ward 4 had had no newly acquired cases of MRSA for two years and no cases of C. difficile for 22 months.
- For November 2014, 67% of patients had said that Ward 7 was clean and 77% of patients had said the bathrooms were clean.
- Cleaning trolleys, some with cleaning materials on them, were not always locked away when not in use.
- In the dirty utility room on Ward 4, we found that both sinks had damaged enamel and the wooden panel board beneath the sinks was damaged. This represented a potential risk for infection control. Staff said this room was to be refurbished in early 2015.
- Most communal toilets we saw were visibly clean and had appropriate hand-washing facilities. However, we saw several examples where communal bathrooms and toilets were not clean. For example, three toilets and shower rooms we looked at on Ward 3 were not clean; toilet basins were unclean and there were tissues on the floor. One male toilet had a perching stool that had a tear in the plastic seat cover. We found a small amount of mould in the corner of one shower cubicle. The paintwork in these toilets and shower areas was in a poor state of repair. We also saw that the covers to ceiling lights contained dead flies. These areas had cleaning schedules showing that the rooms had been cleaned that morning at 8am, five hours before our visit to the ward. Senior staff said these rooms were to be refurbished in early 2015.
- On Ward 4, we looked at two toilets and two shower rooms and found that not all areas were visibly clean. Three out of four toilets were not clean and one shower room had a communal plastic chair that had a ripped plastic seat cover, which presented an infection control risk. The flooring in two of the rooms was not sealed at the base of the toilets. One toilet did not have a dignity curtain. One shower room had a tap on the sink that was not secure and one of the handrails was rusted. We checked the cleaning schedules for these four rooms and found that none had been signed to say that the rooms had been cleaned for two days, which was not in accordance with the hospital's policy.
- On Ward 8, we saw a patient who was being cared for in a side room due to having an infectious disease use a communal toilet opposite their side room and then return back to their room. This was not seen by staff, so we informed a senior nurse as this represented a potential risk to other patients if they used the same toilet.
- On the same ward, we also saw a male patient use one of the toilets designated as female only; this was not witnessed by staff. We found that this toilet was not clean. Staff ensured that the room was cleaned when we brought this to their attention.
- Nurses told us that domestic assistants used colour-coded mops and buckets but not all staff were able to tell us which were used for different areas. Some staff knew to use a white bucket for cleaning general ward areas but some staff said they would use a yellow bucket (which, according to the hospital procedure, should be used in side rooms only for individual patients).
- Daily mattress checks were being carried out on Ward 4 and staff said that mattresses were replaced when required.
- Wards generally did not have body fluid spillage kits available for staff to use. Ward 11 had a kit but staff said it had never been used.

Environment and equipment

- The environment was generally clean and tidy, and the decor was mostly well maintained. Clinical areas were generally well maintained.
- There were systems in place to maintain and service equipment as required. Hoists had been serviced regularly and all but one hoist had stickers on them showing when the next service test was due. Staff were able to show us the recent service visit record for the one hoist that did not have a sticker showing the most recent service date. Most portable electrical equipment had been tested regularly to ensure that it was safe for use. However, we found a toaster in use in the kitchen area near Ward 8 that did not have an electrical safety certificate on it.
- Not all areas provided a safe environment where health and safety risks were recognised and addressed. In one main corridor on the first floor, which was fully accessible by patients and the public, we found that a workman's trolley with a variety of equipment, including saws, hammers and drills, was left unattended for over 10 minutes. We reported this to a senior staff member, who took action to address the concern.
- We noted on some wards that sluice rooms were not always lockable, but staff were aware of the potential risks if people with cognitive impairments went into these areas. However, on Ward 3, the dirty utility room was not locked and we found bleach tablets on a worktop that had not been locked away. These chemicals could have presented a risk to patients or visitors if they had accessed this area. This room also had damaged wooden panels at the front of the sinks. Staff did not know if these wooden panels were to be replaced. Senior staff told us that Ward 3 was to be refurbished in early 2015.
- The door to the kitchen area for Ward 11 was not closed and we found chemicals on the floor that presented a risk of harm and had not been stored securely. The microwave did not have a certificate of electrical safety on it so we brought this to the attention of the ward sister.
- Most storerooms in ward areas were locked, but we found that the storeroom on Ward 7 was open and contained a variety of medical equipment (including hoists and nebulisers) that patients or visitors could have accessed. This storeroom had a sign on the door saying 'Fire Door, Keep Locked', but the door had been left unlocked. We found a wheelchair in this room which was not safe to use but there was no sign on it warning staff not to use it.
- In the kitchen area between Ward 9 and Ward 8 (MAU), we found that fridge temperatures had not been recorded daily; there were 50% gaps in the past eight days.
- In this kitchen area, which was accessible to patients and visitors as the door was not locked, we found cleaning chemicals that posed a hazard to people's health on a shelf. We brought this to the attention of a senior nurse as the chemicals were not locked away in accordance with the hospital's policy.
- Oxygen cylinders were not always stored in accordance with trust procedures, and not all storeroom doors were locked. This represented a potential risk that oxygen could have been accessible to visitors or patients with a cognitive impairment.
- On Ward 8, we found that one of the bay fire doors was being propped open using a clinical waste bin. This had been reported to the maintenance team.
- We also found some hoists in corridor areas on Ward 11 that did not have their brakes on when not in use. This represented a potential risk if a patient with mobility difficulties were to use them to steady themselves when walking past. Hospital policy was for all hoists and wheelchairs to have their brakes on when not being used.
- We found that the bathroom on Ward 11 was being used to store equipment, including a bed, a table, two mirrors and a rota stand (a moving and handling aid). Staff said the bathroom was still being used by patients at weekends and that a risk assessment for the storage of equipment and furniture in this room had not been completed.
- Daily checks of resuscitation equipment were carried out on wards and recorded. Generally, checks were carried out and recorded in accordance with trust procedures.
- The trust had appropriate systems in place to manage the risk from water-borne viruses, and regular tests had been carried out.
- Ward 9 was specifically designed to provide an appropriate environment for people living with

dementia; for example, there was dementia-friendly and appropriate decor and flooring, and appropriate lounges for activities. Side wards used for patients who were at risk of falls were visible to the majority of staff.

Medicines

- Medicine cupboards had an electronic system for dispensing medicines. These cupboards were locked when not in use.
- On Ward 7, the cupboard containing intravenous fluid bags was not locked. Staff confirmed that this was not in accordance with the hospital policy, as this cupboard should be locked when not in use.
- On Ward 4, we found that the cupboard containing blood monitoring and tracheostomy kits in the clinic room was not locked; this was not in accordance with hospital policy. Nurses confirmed that this cupboard should have been locked.
- Generally, we found that clear systems were not in place to monitor or record the room temperatures where medicines were stored. Clinic rooms had wall-mounted thermometers but staff said temperature checks were recorded "only in the summer". Some of the medicines we saw stated that they needed to be stored below 25°C. Also, intravenous fluids that needed to be kept below 25°C were stored in this area where the room temperature was not being monitored. We brought this to the attention of the nurse in charge.
- We checked the controlled drugs record on Ward 4; it had been completed accurately, with two nurse signatures at all times.
- Wards were recording medicine fridge temperatures in accordance with trust policy.
- Nurses wore red tabards when administering medication, in accordance with trust procedures.
- Staff said that they had had relevant training, and that their competencies for medicine administration were assessed regularly.
- On Ward 7, allergies were recorded on the drug records we looked at. When we looked at the records of one person, we found that three medicines had not been signed for during a period of 12 days.
- On Ward 8 (MAU), we looked at three patient records and found three gaps in the medicine records for one person. It was not clear whether this person had received their medicines at the required time or not.
- Drug charts did not routinely record if oxygen had been prescribed for patients. Staff said this was due to the varying dosages of oxygen given based on the patient's needs and to meet their required blood oxygen saturation levels.
- Nursing staff told us that, if they had any medicine queries, they had access to pharmacist advice at all times, including an out-of-hours pharmacy service. We found that the pharmacy team provided an efficient clinical service to ensure that people were safe from harm.

Records

- The hospital used paper-based records. The hospital was in the process of arranging demonstrations of a potential new electronic patient records system.
- Some wards had lockable patient note trolleys but not all trolleys were able to be locked when not in use. For example, all three trolleys we saw on Ward 7 could not be locked. Three sets of patient notes were left unattended on top of a trolley in Ward 3.
- Some ward patient boards respected patient confidentiality by using symbols to denote medical conditions (a falling leaf to denote risk of falls and a forget-me-not flower for dementia). We saw that patient details and investigations they were due to have were clearly displayed on some wards' patient noticeboards.
- We looked at the documentation kept to record people's vital signs observations, fluid balance charts, food intake and repositioning charts. We found inconsistent recording on some of the wards that we visited. For example, on Ward 7, fluid intake and output records were filled in at the time, with charts recording running totals. On this ward, the two-hourly care rounding records had been completed accurately for the three days we looked at. However, for two patients, an electrocardiogram (ECG) record had not been signed or dated by a doctor, as was the trust's procedure. On Ward 8, we looked at three patient records and found gaps in one patient's records in recording their bowel habits, which was important given their presenting condition (they had an infectious disease).
- We noted that not all updates and amendments to nursing risk assessments and care plans had been dated or signed, so it could have been difficult to check who had made the entry if required.

- In one patient's notes on Ward 7, we saw a copy of a facsimile referral that referred to a different patient of the opposite gender and had been incorrectly included in this patient's notes.
- On Ward 8 (MAU) we found that one of the computers had been used and then left unattended without the screen being locked. This represented a potential risk that visitors could access confidential information about patients. On this ward, we also saw patients' notes left unattended on metal trolleys in the patient bay areas for significant periods of time. The patient whiteboard next to the nurses' station displayed all patients' names clearly, so visitors to the ward could read this information. Similarly, we found a computer terminal on Ward 4 that had been used but the screen not locked.
- Wards carried out an audit of at least 10 sets of nursing notes each month. Some wards reported being behind on the nursing note audits due to staffing pressures.

Safeguarding

- Adherence to safety and safeguarding systems and procedures was monitored and audited on a risk basis, and necessary actions were generally taken as a result of findings.
- The trust reported that it generally took a proactive approach to safeguarding, and focused on early identification, so that people were protected from harm and so that children and adults at risk of abuse did not experience any abuse.
- There were effective safeguarding policies and procedures, which were generally understood and implemented by staff, including agency and locum staff. We saw information posters, relevant contact details for the safeguarding adults team and copies of the trust's policies about safeguarding in the ward office of Ward 7.
- The trust had a safeguarding lead for the hospital. We found that there was effective multidisciplinary communication with safeguarding leads in other organisations, and all referrals and concerns were triaged by the local safeguarding authority. Staff told us that this worked quickly and efficiently to safeguard people from harm. Staff completed a 'First Account Referral' form for cases of alleged abuse and would send this to the hospital's safeguarding lead.
- We found that the majority of safeguarding investigations were carried out within the target timescale of 28 days, and we saw evidence of effective protection planning to keep people safe, apart from discharge planning. Monthly reports were produced on safeguarding activity for senior managers.
- Ward managers had access to staff training records. We found that, on Ward 7, 93% of staff had received level 2 safeguarding adults training as of September 2014.
- Staff told us that safeguarding training was one full day, and included the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS).
- Not all staff were fully aware of the trust's whistleblowing procedures. Some staff did not know which external agencies could be contacted with a whistleblowing concern.

Mandatory training

- Staff told us that they had had mandatory training events annually and that these events included infection control, moving and handling, and health and safety. Some staff told us that at times, covering the wards took priority over training. Domestic staff also had mandatory training provided, they said.
- Ward managers had access to staff training records. We found that, on Ward 7, 100% of staff had received mandatory training as of September 2014.
- Staff said that they had had dementia awareness training as part of their mandatory training.
- Senior staff said that the foundation training provided by the trust for junior doctors (F1 grade) was the third best in the country.
- As of October 2014, 93% of staff in medical wards had completed mandatory training, which was better than the trust target of 90%. Senior staff said that priority was given to staffing the ward rotas so staff were not always able to attend training.

Assessing and responding to patient risk

- The hospital used the trust's National Early Warning Score (NEWS) tool to record patient observations at regular intervals and to calculate an overall score designed to alert nursing staff when a patient was showing signs of deterioration. Based on the scoring matrix, a review by a doctor would then be requested.
- The hospital was implementing an electronic system for recording patient observations based on the NEWS tool; this electronic recording system was used on all wards. Staff said they had been given training on how to use the system and how to input patient observations onto

handheld devices. All patients' electronic observations were accessible to senior nurses via a desktop computer at the nurses' station; this also showed when each patient was due to have the next set of observations taken and recorded. This electronic data was available to doctors throughout the hospital; however, the electronic system did not automatically make a referral to a doctor to review the patient if their NEWS indicated that a review was needed. Nurses would make the referral and record this on the patient's written notes.

- CCU had appropriate nursing cover throughout the day and night. The trust also had two heart failure nurses on duty weekdays. They provided an 'in-reach' service to other wards to support patients with heart problems. These nurses worked 9am – 5pm Monday to Friday.
- Senior staff on MAU and Ward 3 said that, when a patient required one-to-one care from a nurse due to behavioural or unstable conditions, this request was escalated to the ward manager and then to the matron for agreement, and that all such requests were agreed and extra staff were provided.
- The hospital followed the trust's policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. Staff said that a 'sepsis box' was available in the hospital's emergency department and would contain the appropriate range of antibiotics to facilitate immediate antibiotic treatment for those patients with suspected sepsis. The care pathway for suspected sepsis would be commenced in the emergency department. Wards did not have 'sepsis boxes' available but did have access to appropriate antibiotics when required.
- Staff on Ward 7 said that there was an escalation policy for requesting urgent doctor reviews of patients and that this policy had been implemented in January 2013.
- The trust had provided training for nurses and healthcare assistants (HCAs) in recognising when patients were deteriorating.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if any shifts were not covered. Senior staff said that they would carry out a risk assessment if their ward was short-staffed and escalate this to senior managers. Staff said that, at times, nurses and HCAs would be asked to work on other wards to provide cover. Some wards reported a recent increase in short-term sickness. Senior nurses were able to tell us about their ward's staffing vacancy position and what stage the recruitment process was at. Staff said recruiting new nurses was a lengthy process at times and was not always successful.
- Wards displayed nursing staffing information showing the planned and actual number of qualified nurses and HCAs on duty for the day. Ward 7 had four qualified nurses on duty in the morning and afternoon and four HCAs in the morning with three in the afternoon. This met the planned rota for the day of our visit. For the night, the ward rota had planned three qualified nurses, but one shift was yet to be covered. For HCAs, the ward had planned three for the night; again, one shift was yet to be covered. This ward had 28 patients, so the nurse-to-patient ratio was 1:7 in the day and 1:9 at night. The planned skill mix (the ratio of qualified staff to HCAs) was 50:50 in the mornings, with 57:43 in the afternoon and 50:50 at night. Staff generally felt that the nursing staff skill mix was appropriate.
- Staff on Ward 7 said that sometimes shifts could not be covered by bank or agency staff and that, on average, twice a month the ward would be short-staffed. Ward 7 had nursing staff vacancies and staff told us that three nurses were due to start (including two nurses recruited from overseas).
- Ward 8 (MAU) had a planned nursing rota of five qualified nurses on duty in the day to care for 28 patients. The nurse-to-patient ratio was 1:7, as one nurse was usually supernumerary and acted as the ward coordinator and attended the post-admission ward rounds. At night, four qualified nurses were on duty, with a nurse-to-patient ratio of 1:7. Normally, there would also be four HCAs on duty on each shift, but on the day of our visit the ward was trying to arrange cover for one HCA for the afternoon and night shifts. MAU generally had one trained nurse on duty for each of the five bay areas, staff told us.
- Ward 8 had five qualified nurse practitioners who had undertaken a relevant degree course, and there were also two nurse prescribers within the staff team. Generally, there would be two nurse practitioners on duty in MAU, and sometimes three, during the day.
- Ward 3 had a qualified nurse-to-patient ratio of 1:7 during the day and 1:9 at night. When we visited, the ward was fully staffed and had increased the number of HCAs at night to three, to reflect the needs of the

patients on the ward at that time. The ward used agency staff at times, and had agency induction sheets that would be used when a new agency staff member worked on the ward.

- Ward 11 had a qualified nurse-to-patent ratio of 1:6 in the morning, 1:8 in the afternoon and 1:12 at night. They were supported by six HCAs in the morning and four in the afternoon and at night. On the day of our visit, two physiotherapists, three occupational therapists and two therapy assistants were on duty.
- The ambulatory care unit was led by nurse practitioners and there were usually two on duty most days, staff told us.
- Shift patterns for nurses and HCAs were 7.30am to 3.30pm, 1.30pm to 9.30pm, and 9pm to 8am for the nights. Each shift had a handover period and staff told us that handovers were usually carried out at 7.30am and 9pm. Typed handover sheets (called the safety briefing) were used by the nursing staff. Staff told us that, generally, the handovers they received gave the appropriate level of information for them to be able to provide appropriate care for the patients.
- Staff told us that one-to-one care could be provided for those patients at risk (for example of falling) and that this was usually from additional HCAs.
- Staff told us that incidents resulting from the ward being short-staffed were reported using the hospital's electronic incident-reporting system. Senior staff said that risk assessments would be carried out in accordance with trust policy if wards were short-staffed.
- Senior nurses said that, in times of need, and based on risk assessments, nurses would be asked to work on other wards. Staff told us that sometimes the trust required staff to work on different wards if there were staffing shortages elsewhere; not all staff felt confident about working on unfamiliar wards, but most understood the need to maintain safe staffing levels across the entire hospital.
- Doctors said that some wards were reliant on bank and agency nurses and that this led to inconsistent care delivery for patients. However, doctors said that they were not aware of any adverse incidents caused by the difficulties in recruiting permanent nurses.
- The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was used by the trust to report on its monthly safer staffing levels information.
- We observed a morning handover between staff on one ward, and we saw that handover sheets were used; these listed people's conditions and treatment. Staff gave detailed handovers, including the person's co-morbidities.
- Some wards reported higher than average staff vacancies and sickness and were reliant on bank and agency staff to maintain staffing levels. Staff told us that they tried to use the same staff, so there was consistency in the level of care provided for people.
- The newly employed staff we spoke with told us that they had received a good induction and that there was effective support during this process.

Medical staffing

- The trust had 70 whole-time equivalent medical care doctors with 27% at consultant level; this was lower than the national average of 33%. The trust had a lower proportion of registrars at 29% than the national average of 39%. The trust had a significantly higher proportion of junior doctors at 37% compared with the national average of 22%.
- Junior doctors worked from 8am to 4pm or 5pm. After 5pm, doctors would be on call on a twilight shift rota. The hospital had a 'hospital at night' team that started at 9pm; the team included doctors and clinical nurse practitioners. Consultants generally worked weekdays and would work an on-call medical rota at the weekends. There was a consultant on site seven days a week from 8am to 8pm.
- Doctors said that there was a dedicated 'hospital at night' team for doctors, and that there were formal face-to-face handovers between day and night doctors. We observed one morning handover between the night team and the day team and saw that patients' priorities, staffing levels and any incidents were discussed.
- The medical handover that we observed was efficient, and there was effective communication displayed regarding people's conditions.
- Ward 7 had three cardiology consultants and one general physician with an interest in diabetes and endocrinology. Ward rounds led by consultants for cardiology took place on Monday mornings, Tuesday afternoons and Friday mornings. General medicine ward rounds took place on Mondays and Thursdays on Ward 7. Staff told us that only post-take (new admissions) medical ward rounds occurred at weekends.

Medical care (including older people's care)

- The medical team for cardiology on Ward 7 consisted of three consultants, two cardiology specialist trainees and two junior members of the team (at FY1 and FY2 grade[JF1]). The medical team reviewed the consultants' patients daily during the week. They also took part in the on-call rota, and therefore not all were present on the ward each day.
- Ward rounds in the CCU took place daily.
- Ward 8 (MAU) had two consultants and one registrar; a third consultant was being recruited. Ward rounds took place twice a day, including the new admissions ward round (post-take ward round) at 8am. This ward usually had a minimum of one consultant and two junior doctors on duty each day. A handover tool, which detailed presenting conditions, risks of falls and nutritional status, was used to ensure that accurate, consistent information was given.
- MAU also had appropriate input from doctors from certain specialties, including an in-reach service from cardiologists and gastroenterologists when required.
- Doctors on MAU told us that the support, training and opportunity for experience on this ward were very good. The pastoral care provided by the hospital was also very good and there was a team approach to learning.
- Ward 3 (the gastroenterology ward) had two consultants during the working week. This ward relied on the medical care service on-call doctors for cover at weekends and in the evening. Nurses said that there were not enough doctors at the weekend. The respiratory ward did not have specialist consultant cover out of hours.
- The hospital had only one diabetologist consultant, which meant that junior doctors sometimes assessed patients.
- Ward 11 (the stroke ward) had only one stroke consultant. Staff said that general physicians would provide cover for the ward during periods when the consultant was on leave.
- A doctor we spoke to said that their induction was "very good" and that there was excellent support from senior doctors.
- The majority of people we spoke with said that, when they needed to, they saw a doctor quickly.
- An assessment by Health Education North West in October 2014 reported that the medical handover was "exemplary" and junior doctors praised the handovers for both patient safety and educational merit.

Major incident awareness and training

- The trust had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents, such as bad weather or illness.
- Patient safety information was collated and audited, and feedback was given to ward teams on a monthly basis.
- Senior staff told us that the trust had business continuity plans in place, and had systems and processes in place to be able to respond to major incidents.
- The trust had made its business continuity plans available on its internal computer system for staff to access, but not all staff we spoke with were aware of this.
- Staff were aware of emergency protocols and fire safety risks. Staff told us that fire drills were carried out routinely. We noted on some wards that designated fire doors to the kitchen areas were propped open; this was not in accordance with the trust's fire procedures. We also saw on one occasion, on Ward 3, that a chair had been placed in front of a designated fire exit.
- Fire fighting equipment was available and had been tested regularly.

Are medical care services effective?

Requires improvement

Care was generally provided in line with national best practice guidelines and the trust participated in all the national clinical audits where they were eligible to take part. Performance and outcomes did not meet trust targets in some areas. There was evidence of progress towards providing services seven days a week, but this had not been consistently achieved across the medical care service. Most staff said they were supported effectively, but there were limited opportunities for regular formal supervision with managers.

Care planning effectiveness was variable, and care plans were not generally person-centred. Care plans for people living with dementia were not effective. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes. Staff uptake of

mandatory training met the trust's target. We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable.

Evidence-based care and treatment

- Staff carried out accurate, comprehensive assessments that covered most health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. They developed care plans to meet some identified needs. The care plans that were in place were mostly reviewed and updated regularly. People's care and treatment were usually planned, and were delivered in line with evidence-based guidelines. However, the care plans we looked at were not person-specific and did not always reflect the holistic needs of the patients.
- On Ward 7, we looked at the care plans for one patient with confusion who was displaying challenging behaviours; this patient was now receiving one-to-one care from staff. Clear, personalised nursing care plans were not in place for staff to follow in order to meet this patient's behavioural and cognition needs. Generic care plans were in place for anxiety and acute confused states, but these did not give appropriate guidance for staff on how to meet this patient's needs. The Patient Passport, an assessment form for family to complete about the patient's needs, had not been completed. Staff said that they did receive a clear, daily handover about the patient's needs. The personal hygiene care plan for this patient had not been completed and the falls and pressure ulcer prevention care plans had not been fully completed.
- On Ward 7, we saw that a patient living with dementia, who had a DoLS authorisation and was displaying aggression, did not have a nursing care plan in place to give clear guidance for staff on managing these behaviours. The nursing care plans did not record the fact that this patient had a DoLS authorisation in place.
- On Ward 11, we found that one patient with a cognitive impairment did not have personalised nursing care plans in place. The ward matron said that the hospital was planning to review nursing care plan documentation as part of the electronic patient record systems implementation.
- On Ward 7, we saw that one patient, who was nutritionally at risk according to the risk assessment completed, did not have a nursing care plan in place for staff to follow to manage the risk of nutritional neglect. This patient had been referred to a dietician but there was no care plan in place to reflect the dietician's advice, so staff did not have clear guidance to follow. Senior staff confirmed that a nutritional care plan should have been in place and took immediate action to complete one.
- On Ward 8 (MAU), one patient who was living with dementia did not have a personalised nursing care plan for the management of their anxiety or for their behaviours that were disruptive for other patients. Another patient we spoke with said that they had been awake most of the night as this patient, who was next to them, had been "shouting out all night".
- On Ward 8 (MAU), we saw that the manual handling plan for one patient had not been updated. It stated that two staff could support the patient, but the patient now required the use of a hoist for transfers. The manual handling plan did not specify the use of slide sheets for repositioning the patient in the bed, but staff confirmed that they were using slide sheets.
- On Ward 8 (MAU), we saw that repositioning charts did not always specify the frequency of repositioning required. The charts of one patient, who had a grade two pressure area, did not specify how often they should be repositioned. Staff were repositioning regularly, but the chart lacked clear guidance.
- On Ward 8 (MAU), we saw one patient who had pressure damage to their skin and had a very high risk assessment score for skin damage. Their nursing care plan did not state that they needed to sit on a pressure-relieving cushion when in a chair. Staff confirmed that pressure-relieving cushions were used and that the care plan should have reflected this. Also, this patient did not have a completed nutritional risk assessment. Staff confirmed that this should have been done the previous day and took immediate action to review this patient's care plan and assessments.
- Senior staff on CCU and Ward 7 said that appropriate systems were in place and staff administered care in line with national NICE guidelines. There was an admission policy in place that included the three levels of care provided by CCU (level one was for minimal nursing support; level two was for cardiac monitoring; and level three was for intubation of patients).
- Wards followed the trust policy for emergency oxygen therapy guidelines, which was adapted from the British Thoracic Society guidelines of 2005.

- We saw from patient notes that VTE assessments had been completed and had been reviewed.
- The hospital had implemented the British Thoracic Society's guidance for community acquired pneumonia (CAP), as recommended by NHS England in 2014. This aims to improve the administration of antibiotics within four hours of admission to hospital. We saw that the hospital used a care pathway for the management of CAP; the forms used were dated March 2012 and were due for review in July 2014, but staff did not know whether this pathway had been reviewed.
- The hospital had a care pathway in place for managing patients' withdrawal from alcohol, based on guidance from the local alcohol liaison service in the community.
- Wards carried out local audits on a monthly basis, including the NHS Safety Thermometer audit, which looked at the prevalence of pressure ulcers, falls and urine infections associated with catheters, and whether VTE assessments had been completed.
- Staff said that the hospital had a culture of using clinical pathways and that these pathways focused on certain conditions: for example, acute chest pain and paracetamol overdose. We saw evidence of clinical pathways for pulmonary embolism, atrial fibrillation, seizures, stroke, deep vein thrombosis and acute kidney injury being used on Ward 8 (MAU).
- Ward 3 had clinical pathways in place for alcohol detoxification, liver abscesses, ascites (fluid in the abdomen), gastrointestinal bleeds and acute kidney injuries. The ward had also introduced a diabetes management pathway in the previous few weeks.
- The hospital's sepsis care bundle was based on national guidance and senior staff said that they had received sepsis management training.
- Wards also carried out a weekly memory screening audit to assess whether these assessments had been completed and to provide information on how the hospital performed against the Commissioning for Quality and Innovation (CQUIN) goal.

Pain relief

- Generally, wards had effective systems in place to assess and provide pain relief for patients.
- A pain assessment tool was used to monitor patients' needs in this area. We saw that patients on Ward 8 (MAU) had had these assessments completed in accordance with the hospital's procedures.
- Patients generally told us that they received appropriate pain relief when required.

Patient outcomes

- The trust's risk-adjusted mortality index (RAMI) was 85 for the most recent 12-month cumulative period; this remains better than the score for similar trusts, which was 90. It was also better than the equivalent RAMI for the same period in the previous year, which was 92.
- The trust's summary hospital-level mortality indicator (SHMI) was 0.99 for the 12-month period to April 2014; this was the same as the score for peer trusts.
- The trust had an effective system for monitoring patients' 'free from harm' care. The system was delivered in each ward area, and monthly feedback reports were cascaded to staff. Information on the main performance issues and safety risks was displayed on the wards' performance boards.
- Safety Thermometer audits were carried out by each ward and looked at the instances of falls, newly acquired pressure areas, VTE assessments and urine infections for patients with a catheter. Wards also carried out an audit of at least 10 sets of nursing notes each month.
- Wards also conducted monthly audits of resuscitation trolleys, hand hygiene and housekeeping.
- Outcome measures for wards included completion rates for VTE assessments, memory screening and electronically produced patients' discharge letters. Ward 11 had achieved 100% compliance with these outcome measures the previous month.
- Senior nurses said that the main outcomes that wards measured were harm-free care, complaints and patient experience surveys.
- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP). For the period January to March 2014, the trust was among the worst nationally for its audit results. Thrombolysis, specialist assessments, occupational therapy and speech and language therapy had the worst performance against the audit targets, but the trust had put action plans in place to address these areas. The trust had taken action due to the poor audit outcomes by ceasing to provide a hyper-acute stroke and thrombolysis service at this hospital, so that patients would receive safe, appropriate care and treatment at other local NHS trusts. Senior staff told us that a review was under way of therapist services. Staff said that the results for the

period April to June 2014 had improved (but had not yet been published) but the specialist assessment audit score was still poor as the ward had only one stroke consultant and there were still delays in patients being assessed by a speech and language therapist.
- For the National Diabetes Inpatient Audit (NaDIA) in September 2013, the hospital performed better than the national average in 13 out of the 19 audit measures. Action plans were in place to address the six areas where the hospital performed worse than the national average.
- The trust achieved all three elements of the dementia CQUIN goals for the year 2013 to 2014.
- The heart failure audit for 2012/13 showed that the hospital performed better than the national average in four areas, and slightly worse than the national average in six areas.
- In the Myocardial Ischaemia National Audit Project (MINAP) for the year 2012/13, the hospital performed better than the national average in one area, the same as the national average in one area, and worse than the national average in the third area.
- Data from the year 2012/13 demonstrated that the trust performed the same as the national average for people with nSTEMI (a common type of heart attack) being seen by a cardiologist; the trust achieved 93% in the audit compared with the national average of 94%. It performed better for those people who were referred for or had angiography, with 94% of patients having angiography compared with the national average of 76%.
- Also, in the same period, the hospital performed worse than expected against the national average for those people with nSTEMI who were admitted to a cardiac ward; the audit results were 32%, compared with the national average of 53%. The quicker a person is admitted to a cardiac ward, the better their prognosis will be.
- The stroke ward had an average length of stay of four weeks. Patients received 45 minutes a day of occupational therapist and physiotherapist input three times a week; this did not meet the NICE recommended guidance of 45 minutes of therapist input five days a week (Stroke Rehabilitation: Long-term rehabilitation after stroke, NICE guideline CG162, published June 2013).
- The trust reported that it met the 62-day cancer standard (from urgent GP referral to treatment) in the year to October 2014, with overall performance of 89%. This was higher than the trust target of 85%.
- The trust was meeting its target for carrying out mortality reviews.

Nutrition and hydration

- Staff told us that the hospital used red trays and red beakers to indicate those patients who were at risk of malnutrition and dehydration and needed staff support to eat and drink.
- Patients on Ward 8 (MAU) told us that the food was generally very good and that they had a choice.
- All wards had protected mealtime arrangements and notices for visitors about these protected mealtimes were on display at all ward entrances. Mealtimes were protected within the ward areas we inspected. This meant that patients could eat their meals without interruption, and staff could focus on providing assistance to patients who were unable to eat independently.
- We observed that the details of nutritional intake and fluids were not always recorded accurately within patients' records.

Competent staff

- Most staff told us that there were no formal systems in place for regular supervision sessions with their line managers, apart from annual appraisals, but that any issues were addressed via informal support from managers. Staff said that one-to-one supervisions "don't happen".
- Senior staff told us that they had regular supervision sessions that included reviews of their training and development needs.
- Only a small proportion of qualified staff we spoke to said that they had opportunities for clinical supervision. However, there were supervision arrangements in place for newly qualified nurses.
- Most staff told us that they had had an annual appraisal, that their training needs were discussed and individual development plans completed, and that they received copies of the meeting notes.
- Newly appointed staff said that their inductions had been planned and delivered well, including supernumerary time for shadowing experienced staff. One staff member said: "My induction was very good

and I am confident now in what I am doing." Permanent staff were provided with induction packs, but not all ward areas had separate induction packs for agency staff.

- A senior nurse on Ward 7 said they had had a talk about DoLS but it was not a formal training session and they "wouldn't be happy to complete DoLS paperwork".
- The AWARE course (nationally recognised HCA training course) was introduced into the hospital in December 2013 with sessions planned monthly throughout 2014. However, some HCAs said that they did not receive an adequate induction process and that their training and development were only "basic". Some said that no HCAs had achieved a national vocational qualification (NVQ) in care. Some HCAs said that they had not had an annual appraisal.
- While most staff had completed dementia awareness training sessions, not all staff had had the hospital's two-day dementia training. Six staff on Ward 8 (MAU) had undertaken this extended two-day dementia training.
- Nurses on Ward 3 had had training for carrying out swallowing assessments for patients as well as for enteral feeding regimes.
- On Ward 11, all staff had completed mandatory training and had also had dysphasia and life support training and specific training on recognising when a patient was deteriorating. HCAs had also been given specific training for recognising when patients were deteriorating.
- Some 90% of staff on Ward 11 had had their annual appraisal, and the remaining appraisals had been booked.
- For October 2014, medical wards had not met the trust target of 84% compliance for having an annual appraisal, as only 76% of staff had completed their appraisal. However, many staff told us that their appraisal had been booked.
- Doctors told us that there was an effective system for assessment and revalidation.
- Staff on Ward 7 told us that there was no specific cardiology training but the trust offered management of heart failure training. Staff competencies were assessed for the insertion of peripherally inserted central catheters (PICC) lines, which are used to give medicines. Staff also attended ECG training.

Multidisciplinary working

- There was a multidisciplinary collaborative approach to care and treatment that involved a range of professionals, both internal and external to the organisation. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring that assessments were reviewed regularly and kept up to date.
- Meetings on bed availability were held every two hours from 8am to 8pm during the week, to determine priorities, capacity and demand for all specialties.
- Staff told us that multidisciplinary working on the stroke ward was excellent, with clear handovers that discussed the needs of patients and action points for staff. The stroke ward held combined multidisciplinary meetings once a week to facilitate effective communication. Staff also worked on rotation across these two wards.
- We saw that multi-professional medical ward rounds were held daily on Ward 8 (MAU) to ensure that patients' needs were reviewed every day. We observed a post-take ward round at 8am and saw that there was clear, effective communication and multidisciplinary working between the doctors, nurses and pharmacist, who all sought to provide timely and appropriate care and treatment, together with the early consideration of discharge planning.
- Ward 11 had a monthly stroke operations group meeting; this was attended by doctors, nurses, therapists and a dietician.
- Daily ward meetings were held, usually at 8.45am to 9am. These were called the board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed one board round and saw that it was well attended by a range of professionals.
- Staff told us that there was robust multidisciplinary working at ward level, but links with other departments were not always effective. Staff told us that there was effective liaison between nurses and doctors. Doctors told us that nurses knew people's conditions and would report any changes in order to deliver the best outcomes for people.
- The ambulatory care unit had effective liaison with the emergency department and the AMUs.
- A pharmacist told us that they were very much included in the decision-making process with the medical and nursing teams and attended multidisciplinary team meetings regularly.

- On Ward 7, staff worked together as part of a multidisciplinary team to aid patient recovery, with collaboration with physiotherapists, occupational therapists and a social worker based on the unit, and with input from tissue viability nurses and dieticians when required. The CCU had effective links with heart failure nurses and the cardiac rehabilitation team.
- Ward 3 and Ward 8 (MAU) had an effective relationship with an alcohol liaison nurse, who was employed by another trust and worked during the working week. Ward 3 also had good liaison with speech and language therapists.

Seven-day services

- Medical ward rounds were held on each ward on weekdays, but most did not have individual ward rounds at the weekends. Senior staff told us that not all patients were therefore routinely reviewed at weekends but that any patient requiring a review was seen promptly by the duty doctor team. Staff would refer any concerns to the on-call team of doctors at the weekend. Staff reported that there were no difficulties in getting doctors to review patients promptly at the weekend. During the night, staff would refer patients to the 'hospital at night' team for review.
- The hospital had a medical consultant on site at the weekend from 8am to 8pm and then on call during out of hours.
- The trust had a doctors' on-call rota for evenings and weekends; most ward areas did not have specialist doctor cover out of hours. There was a consultant on-call rota operated by the trust out of hours.
- A site manager was on duty each day including weekends from 1.30pm – 8.30pm; this was a senior manager and matrons were included in the site manager rota.
- The hospital's pharmacy was open on Saturday and Sunday mornings to support patients who required medicines for discharge. The on-call pharmacist service also arranged medicines for discharges.
- Therapists worked weekdays from 9am to 5pm and were on call at the weekend. A chest physiotherapist worked seven days a week from 9am to 5pm. Speech and language therapists did not work at weekends, and staff on the stroke ward reported some delays in assessments being carried out, particularly over the weekend. This meant that some patients awaiting a swallowing assessment had a nasogastric feeding tube inserted and were 'nil by mouth' until they could be assessed after the weekend.
- On the stroke ward, rehabilitation-trained HCAs followed therapy plans at weekends according to therapists' assessments.
- Ward 8 (MAU) had nurse practitioners on duty during the day from 7.30am to 9pm seven days a week.
- On Ward 8 (MAU), a consultant was on site from 8am to 8pm and would conduct a ward round daily, as well as providing support for other medical wards and seeing any patients in outlying beds who needed to be reviewed.
- Staff told us that the process for having X-rays taken, and for getting results, could be slow at times, particularly in the evenings and at weekends, due to the out-of-hours cover rota. Staff said that the CT scan service was very effective and was now available 24 hours a day, seven days a week.
- Some wards had a nurse acting as a discharge coordinator. Patients considered suitable for weekend discharges were identified before the weekend in order to try to facilitate appropriate discharges.
- The discharge lounge was open during the week, but not normally at weekends.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable. Some assessments correctly recorded specific decisions and the reasons for the judgement made, while others did not. The involvement of family members or people's representatives was recorded in only a minority of cases.
- Not all staff had received DoLS and MCA training.
- We saw that patient consent forms had been completed when needed. However, for one patient on Ward 7, the confirmation of consent had not been signed by a healthcare professional, which was not in accordance with the hospital's policy for consent.
- For one patient on Ward 7, staff told us that a DoLS assessment had been authorised and was in place, but we found no record of the assessment or authorisation on the patient's notes. Staff were not able initially to tell us when the DoLS assessment had been carried out and there was no date for when the DoLS authorisation had

commenced on the staff handover sheets that we looked at. The previous day's handover sheet stated that this patient had a DoLS authorisation in place. The senior nurse on the ward confirmed that they would have expected to see the relevant DoLS assessment and authorisation on the patient's notes. This patient did not have any recorded mental capacity assessments on their notes. There was no record of this patient having had a DoLS authorisation in place in either the nursing or the doctor's notes. We visited the ward the next day, and staff told us that the patient's handover notes had recorded that a DoLS authorisation had been in place for nine days and that staff had cared for them as though a DoLS had been in place for this period. We saw that the ward had now compelled a DoLS urgent authorisation, but there was no clearly recorded mental capacity assessment on the patient's notes to inform this urgent authorisation. This patient had potentially been deprived of their liberty for a period of nine days as the hospital's procedure for DoLS authorisations had not been followed.

- In another case on this ward, we saw that an urgent DoLS assessment had been authorised. However, while the medical notes stated that this patient had a cognitive impairment, there was no time- or date-specific mental capacity assessment recorded to inform the DoLS assessment. Staff were maintaining a safe environment for the patient.
- On Ward 11, one patient had a DoLS standard authorisation in place. An MCA assessment had been completed by a junior doctor one week prior to the date of the standard authorisation but it did not record the specific decision that had been made, nor had the best interest decision made by the doctor been recorded. There was no reference to the DoLS authorisation or mental capacity assessment in the medical notes, which the ward matron said was not in accordance with trust policy.
- Wards had a DoLS folder in ward offices that contained template forms for carrying out mental capacity assessments and for urgent and standard DoLS authorisation assessments. Staff said a DoLS assessment would be completed and emailed to the hospital's legal advisers and a copy should also be placed in the patient's notes.
- We looked at four records on Ward 7 and found that two 'do not attempt cardio-pulmonary resuscitation' (DNACPR) records had been completed according to trust guidelines. One did not have the relevant box on the form completed to state whether the patient should be resuscitated or not. A second did not record the reason why the patient had not been involved with the decision about resuscitation or why their relative had been informed instead. Neither of these patients had a mental capacity assessment recorded to show whether or not they had the capacity to be involved in the decision.

Are medical care services caring?

Good

Patients told us that staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey, the Friends and Family Test (FFT), was cascaded to staff teams. Overall, medical inpatient services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care. Staff in all roles put significant effort into treating people with dignity. Patients generally felt supported and well cared for. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.
- We saw that interactions between staff and other people were generally positive, respectful and caring. The interactions we saw between doctors and patients during a ward round on Ward 8 (MAU) were very caring, respectful and friendly.
- Most people we observed were well presented and appeared comfortable in their surroundings.
- People's dignity was respected while they were being supported with personal care tasks, and dignity curtains

were used when staff were assisting patients. We did see one occasion when a nurse did not draw a dignity curtain when supporting a patient to have a nebuliser and medication on Ward 3.
- We saw that healthcare professionals visiting ward areas asked patients if they could view their notes.
- Staff knew people's names, and spoke in an appropriate tone of voice when supporting people. A doctor told us that the nurses "know their patients and their needs". The majority of people were very complimentary about the staff and the care they had received. One person said of the nurses: "They are very good." Another said: "The nurses are friendly." One person on Ward 8 told us: "The care could not be improved." One patient on Ward 8 (MAU) told us: "I know my doctor and the nurses are very nice. They seem very industrious."
- One person on Ward 7 said: "There is no television. I don't go anywhere apart from bed to chair. I don't know if there is a day room." Another said: "They came to change my leg dressings today but didn't have the right dressings so had to come back later."
- Generally, staff supported people to eat in a caring and dignified manner, but we did see one junior nurse standing over a patient while assisting them to eat. After the nurse had left, we heard the patient call out three times as their drink had been left out of reach. This patient also had no call bell to hand to summon help. After five minutes, the nurse did assist the patient with their drink.
- One set of relatives we spoke with said: "We are pleased with the way they are looked after. They are so good with them."
- The majority of people told us that nurses checked upon them regularly and were polite and respectful. The relatives we spoke with were complimentary about the care and attention their relatives had received from staff.
- People told us that staff answered their call bells in a timely fashion, and generally we saw that people had access to call bells and staff responded promptly.
- Staff were able to tell us how the needs of people from culturally diverse backgrounds were met.
- Staff generally respected people's privacy, but some ward rounds we saw were in communal areas, with the possibility that confidential patient information could be overheard by other patients or visitors.
- Five patients we spoke with on Ward 4 were all very positive about the level of care provided by staff and said that they were treated with dignity and respect at all times.
- Wards had recent FFT results on display on their noticeboards. For example, Ward 4 showed a ward FFT score of 4.59 stars out of a possible five stars with a response rate of 45%.
- For July 2014, five out of seven medical wards had an FFT score higher than the national average (which was 70).

Understanding and involvement of patients and those close to them

- All staff we observed communicated respectfully and effectively with patients.
- The care plans we looked at were not personalised for the individual, and most did not reflect the patient's involvement in agreeing to the plan of care.
- Some patients we spoke with across all wards visited said that they were not aware of their care and treatment plans. Many had not seen them.
- Most care plans and risk assessments we looked at had not been signed by the patient or their representative.
- Most people we spoke with said that they had been informed of their conditions and treatment plans. Staff kept people informed of any changes. One patient said they had "been kept well informed of their options. I have a doctor."
- Some staff had an understanding of the MCA and that assessments of a person's capacity were needed if there were reasons to doubt their level of understanding. Staff told us that capacity assessments were carried out by doctors, not nurses.
- Family members said that they were generally kept well informed about how their relative was progressing.
- All wards had appropriate signs in place so that people would know which members of staff were their named nurse and doctor.
- The trust's document for the care of people with dementia – the Patient Passport – was completed and available for staff to read for some people but not for all. People's life stories and likes/dislikes that were included in the passport were not effectively transferred into their main care plan; this was especially true of information on people's behaviours and known 'triggers' for aggressive behaviours.

- Staff told us that the translation service worked well when needed, and we saw posters on display in some ward areas. Wards also had access to independent interpreters when required.
- Wards had information leaflets for patients explaining the ward's ethos and staff roles and what rehabilitation therapy was provided on the ward.

Emotional support

- A stroke discharge pack was available for patients when leaving hospital, giving them appropriate contact details for community support organisations. Stroke patients also received a copy of their stroke care plan for continuity of service in the community when they were discharged.
- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- Most staff said that an extra staff member could be requested if a person needed specific one-to-one support from staff, but that this did not always happen due to the lack of available staff.
- People spoke highly of the hospital's chaplaincy service and found it easy to access support.
- Staff told us that timely assessment and support were generally available for people from mental health practitioners.
- The trust had a range of information leaflets available for patients and their relatives to signpost them to other providers of support, including social services and charities.
- Some patients said that they had lost some independence while in hospital, but that staff kept them informed and did offer choices where appropriate.
- Visiting times met the needs of the relatives to whom we spoke. Open visiting times were available if patients needed additional support from their relatives.

Are medical care services responsive?

Good

Problems with the effective discharge of people were highlighted across the medical care service, by both staff and some of the patients we spoke to. While the trust had implemented a dementia care strategy, there was more work to do in terms of efficient care planning to provide effective person-centred dementia care. There was an elevated demand on bed availability at times, and the trust had escalation plans in place.

Services met the needs of patients, although, as noted, this was not always the case for patients who had suffered a stroke. The hospital was looking at plans to reduce the impact of patients with a delayed discharge. We observed a multidisciplinary and integrated approach to the delivery of care that involved nursing staff, HCAs, therapists, medical staff and pharmacists. Concerns and complaints were dealt with at ward level by the ward sisters, who often resolved the issue and avoided the need for a more formal complaint. Information was available for patients on how to make a complaint.

Service planning and delivery to meet the needs of local people

- Although the trust did not offer a hyper acute stroke service, there were systems in place for patients to be seen at other local hospitals. Patients presenting with signs of an acute stroke were transferred to another hospital in the region for urgent assessment and treatment, and the hospital had systems in place that aimed to repatriate patients back to the hospital within 24 hours, where their condition allowed. The hospital had one stroke consultant; this meant that patients were seen by general medical physicians at times.
- The hospital had one diabetologist consultant and no specialist diabetic nurse. This meant that junior doctors commonly reviewed patients and prescribed appropriate medication, as opposed to more specialist practitioners.
- Doctors told us that ideally Ward 8 (MAU) needed four consultants as this would remove the need for consultants in other specialties to do some of the ward rounds. The use of nurse practitioners in MAU supported the timely assessment of patients and ensured that their needs were met effectively.
- Doctors on Ward 8 (MAU) said that direct liaison with colleagues in primary care services could be improved, but that there was effective and strong partnership working with colleagues in the hospital's emergency department.
- Where required, staff would refer patients to dieticians with expertise in nutritional complications, who would assess patients promptly. Gastroenterology consultants

would assess patients for the use of percutaneous endoscopic gastrostomy (PEG) tubes. There was also a specialist endoscopist nurse who was the lead for PEG assessment and enteral feeding. A PEG is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

- Senior staff said that the trust was planning a winter pressures plan to cope with increased demand for beds in the coming months. The trust was engaging with partner organisations, such as the local authority and clinical commissioning group, to address this area of concern.
- Staff on Ward 11 told us that the trust did not yet provide an early supported discharge team for patients with a stroke in accordance with the national stroke care recommended strategy. The trust told us they did provide an early supported community discharge service in South and Vale Royal which was commissioned in 2013/14. At the time of the inspection the trust was in discussion with commissioners about the specification for a service in East Cheshire.
- During the period from April 2013 to July 2014, the hospital met the 18-week standards for referral-to-treatment times in all five specialty groups (including cardiology, dermatology and gastroenterology).

Access and flow

- Ward leaders used the trust's electronic bed management system (the Clinical Realtime Information Solutions or CRIS system). The bed coordinators for wards used this tool to communicate capacity and flow information between wards.
- The hospital had a matron on duty daily in the capacity team who focused on bed capacity and bed management across the hospital.
- The hospital had bed management meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures, for example on Ward 8 (MAU). The meetings took place at 8am, 10.30am, 1.30pm, 4pm and 8.30pm and minutes were taken.
- Senior nurses said that there was good strategic management of bed capacity across the hospital site and effective liaison with the emergency department to monitor patient flow and bed capacity.
- Ward 4 had had 158 admissions in the month of November and the average length of stay was five days.
- Senior staff said that during each weekday ward round, there was a clear focus on effective discharge planning for patients. However, discharges at the weekend were half the number of those achieved during the week and some wards did not always clearly or routinely identify patients for potential discharge.
- Each ward had daily board rounds at around 9am during the week with relevant multidisciplinary professionals to plan potential discharges. These board round meetings had recently been brought forward from lunchtime and the hospital was promoting a 'Home for Lunch' discharge initiative. Staff said that some patients were discharged by lunchtime, though not frequently. Senior nurses said that recent feedback had showed that 28% of patients discharged were now being discharged before lunchtime.
- Ward 7 did not have a designated discharge coordinator; the named nurse for each patient took responsibility for discharge planning. The hospital had a multi-agency discharge team, which worked Monday to Friday but not at weekends or in the evenings. Staff said that most discharges took place during the week, and not often at weekends. Ward 7 did not have any patients with a delayed discharge at the time of our visit. Staff on the ward were not able to tell us of the overall position for the hospital for delayed discharges of patients.
- The hospital's pharmacy was open on Saturday and Sunday mornings if patients required medicines for discharge. The on-call pharmacist service also arranged medicines for discharges.
- The hospital had a discharge lounge. This was open from Monday to Friday, 8am to 7pm. Wards completed a referral form for those patients medically fit to be transferred to this lounge. Staff in this lounge worked closely with the hospital's bed management team. A nurse from the lounge would visit other wards twice a day to support discharge planning. Staff said that this lounge was usually open at weekends from 10am to 5.30pm, depending on the availability of staff. The average patient waiting time in this lounge was up to an hour and the lounge usually had dedicated transport vehicles.
- Ward 8 (MAU) had 28 beds and mainly took referrals from the emergency department and the GP referral unit. The designated length of stay was 24hours but could be extended to 48hours if required. The unit

primarily catered for those patients needing a short-term admission, mainly those patients with a urine infection, breathing difficulties or in need of treatment for alcohol withdrawal. Patients were generally admitted to MAU within 12 hours of their admission to hospital. The ward could have up to 30 admissions per day. Some patients were admitted directly from the emergency department to specialty wards, for example cardiology. Ward rounds (the post-take ward round) took place daily at 8am and at around 5pm.

- Discharge planning commenced on admission to Ward 8 (MAU) and the ward sought appropriate input from the patient journey coordinator to facilitate effective planning. MAU staff had introduced a system for checking that the electronically produced patients' discharge letters were issued and were now reporting 100% compliance with these letters being produced. One nurse on MAU coordinated discharge planning and liaised with the bed management team.
- At the time of our visit, staff on MAU said that no escalation areas were being used by the hospital. Medical patients were generally accommodated as outliers on the surgical wards (Wards 1, 2, 5 and 6) if there were not enough medical specialty beds available. At times of high demand, wards, including the emergency department, could borrow up to six hospital beds from the maternity ward (Ward 4) so that patients could be cared for in appropriate hospital beds in the emergency department until a bed became available on another ward.
- Ward 2 (the day case surgery ward) could also provide up to 15 beds for medical outlying patients. Staff from other wards could be moved to staff this ward when required; one matron oversaw this each day to ensure that staffing levels were appropriate in this area. Other wards would maintain their staffing levels through the use of bank and agency nurses. Staff on Ward 2 said that they could have two to 10 medical patients on any given day and usually those patients were medically fit for discharge. Staff liaised with the patient journey coordinator on more complicated discharges. We spoke to a surgical doctor on this ward, who said they felt well supported by medical colleagues at all times.
- The day prior to our visit, there were 21 medical patients outlying on other wards. Staff said that the number varied each day but there were patients on outlying wards most days. The trust had a policy in place for the medical management of outlying patients. Each outlier ward was 'buddied' with a medical ward so that there was a system in place for ensuring appropriate levels of medical cover for these outlying patients.
- Nurses told us that patients outlying on other wards were not normally discussed at their ward handovers. On the day of our visit, Ward 7 had two cardiology patients outlying on other wards; if there were concerns, staff on the other wards would alert the medical staff.
- The hospital had a rapid discharge service for patients requiring palliative care who wished to be cared for at home.
- Wards had separate bays for male and female patients. Wards 7 and 8 had four bays of six beds each, with two bays each for male and female patients. The ward also had four side rooms available for patients of either gender.
- Staff said that the hospital had introduced a new policy regarding patient moves at night: ideally, no patients should be moved after 10pm, unless they needed to be moved to meet clinical needs. Where patients were moved, staff would carry out a risk assessment. Staff said that, if patients were moved at night due to bed capacity issues in the hospital, these moves would be recorded as an incident using the trust's electronic incident-reporting system. Staff said that patients were moved at night due to bed capacity issues and that this happened frequently. Some patients would be woken up to explain why the move was required, staff told us. Ward matrons said that they did not receive a ward-by-ward breakdown of the number of moves at night.
- Staff told us that some patients had a delayed discharge because they were waiting for care home placements and also because continuing healthcare assessments (CHCs) took a long time. Also, the hospital worked with three different local authority areas, and there was inconsistency in liaison with different social work teams. The trust was aware of these issues and staff said that joint work was under way with stakeholders to progress the concerns over delayed discharges. Senior staff said that the average number of patients with a delayed transfer of care was 20 to 30. The trust was in the process of developing a strategic bed reconfiguration plan and was looking at possible options for a facility for those patients with a delayed discharge.
- From April 2013 to March 2014, 5.2% of occupied bed days were due to delayed discharges.

- The average length of stay for the general medical wards was eight days; this was above the national average of 5.5 days. The average length of stay varied in each medical specialty, ranging from two days in respiratory medicine (elective) to nine days in general medicine (elective).
- Staff on Ward 7 said that delayed discharges of care were common and that difficulties in finding appropriate nursing home places in the community were the main reason for this.

Meeting people's individual needs

- Most people we spoke with knew who their consultant was. However, some did not, and they said that they did not know what their treatment plans were, or when they might be able to go home.
- Not all wards were using the trust's symbols on patient information boards to indicate that a patient was living with dementia.
- The hospital provided a cardiology 'in-reach' team made up of heart failure nurses for non-cardiac wards so that patients could have appropriate assessment when required quickly. This service operated on weekdays but not at weekends.
- The hospital also had a respiratory nurse service operating seven days a week for urgent assessments.
- Ward 11 had a stroke coordinator who assessed patients on other wards as part of an 'in-reach' service.
- There was a lack of dementia-friendly signage and of signs in alternative languages in some ward areas, although we did see posters in different languages in some corridor areas.
- Care for people with dementia, particularly those who became agitated and displayed challenging behaviours, was an area that the trust was looking to enhance. Behaviour charts were available for staff to use to help monitor and understand patients' difficult behaviours. However, we found that these charts were not always being used, although they have been shown to assist with effective care planning. Ward staff could seek support from the dementia advice nurse, who worked in the trust's intermediate care service. Staff told us that the hospital was looking to provide dementia-friendly environments across the hospital and to enhance activity programmes for people living with dementia. Ward 9 had recently been refurbished and was now the hospital's ward for the care of people living with dementia; this was part of the trust's intermediate care service.
- There were no personalised care plans in place for those patients with dementia who displayed aggressive behaviours and there was not always clear guidance for staff on how to manage these behaviours.
- Staff told us that they gave people's relatives the Patient Passport document to complete, but they did not get many completed documents back. This meant that care and treatment were not always delivered to meet people's needs, as staff did not have appropriate guidance to follow.
- Staff told us that mandatory training included some information about learning disabilities and that Patient Passports were used when people with a learning disability were admitted from the local community. Two hospital nurses acted as learning disability liaison nurses and were available for staff seeking advice.
- We saw that one patient with a learning disability had a person-centred care plan in place; this gave clear guidance to staff on how to meet that patient's needs.
- Some areas had patient information leaflets available in different languages. The hospital had a range of information leaflets available for patients and their relatives to signpost them to other providers of support, including social services and charities.
- The hospital had access to a translation service; staff told us that this was effective and met people's needs. Posters were on display about how to access this service.
- Most wards did not employ activity coordinators and staff said that, while activity equipment and games were provided, there was little time for them to sit with patients and engage with them in meaningful activity.
- Wards did not generally have a stock of bariatric equipment but it was usually delivered within two hours of a request being made.

Learning from complaints and concerns

- People generally knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care. However, complaints procedure leaflets were not always readily available in ward areas. Most areas we visited had posters clearly on display regarding the trust's complaints procedures or

the Patient Advice and Liaison Service (PALS). We saw a variety of information posters in the hospital's main corridors regarding complaints procedures and also about the local Healthwatch organisation.

- People's views of the way in which the hospital dealt with complaints were mixed. One person told us that a concern had been dealt with "on the spot" and that they were happy with the resolution. Another person said: "The complaints procedure takes too long to get a response."
- Some patients knew about the hospital's PALS, and leaflets were available in all areas we visited. We saw posters on display in corridor areas outside wards that gave information about PALS.
- Ward leaders told us how they were now working to achieve 'on the spot' resolutions of concerns where possible, and that they would hold meetings with people and their families to seek to resolve any concerns.
- Senior nurses told us that staff from the hospital's customer care team visited the wards daily to speak to patients and their visitors. This initiative had started in October 2014 and feedback was given at the time to the ward and also subsequently in writing.
- In October 2014, there had been three complaints about the medical care service out of a trust total of 13. In September, there had been one complaint.
- The trust produced summary reports of the general themes of complaints so that learning could be shared with all departments.
- Staff told us that there had been a number of complaints regarding the discharge process, and that these usually related to ward discharge processes.
- Learning from complaints was disseminated via team meetings.
- We saw that all wards displayed the compliments they received.

Are medical care services well-led?

Requires improvement

The medical care service was generally well led at a ward level, with evidence of effective communication within staff teams, and the implementation of information boards for staff to highlight each ward's performance. The visibility of and relationship with the management board were less clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. Not all staff felt able to contribute to the ongoing development of their service.

Junior staff said that work pressures, due to higher patient dependencies, were an area of concern. Most staff felt valued and listened to and felt able to raise concerns. However, some staff felt that they were not involved in improvements to the service and did not receive feedback from patient safety incidents. All staff were committed to delivering good, safe and compassionate care. Some staff spoke of 'back to the floor' visits by the chief executive and members of the wider executive team.

Vision and strategy for this service

- Most ward leaders spoke positively about the board's vision and strategy for the ongoing development of the medical care service.
- Some staff were able to tell us about the trust's vision and values.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.
- Some ward leaders felt that the pace of change in recent months was significant and that the staff team needed clarification regarding the workforce reduction plans that were being implemented.
- Some staff said that the assessment documents and care plans were time-consuming to complete and needed to be reviewed. Some had raised this with their managers.

Governance, risk management and quality measurement

- We were told by senior staff that CQC standards were incorporated into the quality assurance programme for the trust.
- Ward leaders were able to tell us about the ward's performance against the trust's targets and objectives, and they were aware of the current risks on the risk register. Ward managers told us that each ward had a ward risk register and that specific action plans were produced for areas of concern. Wards did not have an

overarching action plan or ward development plan. Junior staff were not always able to tell us how the ward was performing, or what actions were being taken to mitigate risks to people.

- Senior staff were aware of the trust's monthly risk-assessed data report (RADaR), which was used to assess ward performance in relation to a range of agreed quality indicators, including staffing levels and harm-free care. This was reported monthly to the trust's board and ward performance was monitored via the safety, quality and standards (SQS) committee and departmental managers. The RADaRs and Safety Thermometer information were accessible to staff but not via an online dashboard on the trust's intranet.
- Senior nurses told us that the RADaRs were sent to matrons and cascaded to ward managers on a monthly basis. Staff were sent the RADaRs via email but senior nurses were not sure how many staff read these emails. The RADaR for each ward was available on the shared storage drive on the trust's intranet, but senior staff said that not many staff actually viewed it as "it was difficult to find". None of the four members of staff we spoke to on one of the medical the wards had heard of the RADaR. Senior staff said that risk areas for the ward were discussed with staff as specific themes, as opposed to discussing the overall RADaR findings. Senior staff said that team meetings did not specifically refer to these audits, but specific themes arising from them were discussed with staff teams.
- Ward 4 was completing an overarching ward action plan on the day of our visit; this was to include specific areas of risk that had been identified by the Safety Thermometer audit information and the trust's RADaR audit report. Areas of risk identified were: agency usage above 10%; appraisals not on target; newly acquired skin damage incidents; and delayed discharges.
- Staff on CCU and Ward 7 said that a risk assessment had been completed recently and discussed at the hospital's SQS meeting. This had related to potential improvements to the environment in order to provide more space; the aim was for CCU to fully integrate with the cardiology ward and be able to provide single-sex areas and to fully comply with infection control protocols.
- Doctors told us that all patients' deaths were reviewed and discussed at the hospital's regular mortality meetings and that information and learning were shared.

Leadership of service

- Most staff told us that leadership at ward level had improved, with clearer communication. For example, performance boards, which highlighted key issues and messages and also recognised staff achievements, were available for staff to read. A few members of staff felt that there was a lack of consistency in ward leadership. Staff said that the director of nursing was aware of the issues affecting staff on the wards.
- Some ward leaders told us that leadership and management courses were much more accessible for them than they had been previously.
- Senior nursing staff and doctors said that leadership from the board and the senior executive team had improved, and that two-way communication was more effective.
- Staff told us that, generally, they were well supported by their managers.
- Some staff told us that the board members and executive team were more visible and accessible to staff, while others said there had been little improvement. Some staff said that the chief executive had visited their wards, while others had not seen the chief executive visit.
- Staff said that there was a regular newsletter, or team brief, available for all staff to read on the trust's internal staff website. Not all staff were aware of the chief executive's meetings for staff.
- Some HCAs told us that they did not know what the ward performance boards were for, and some of the HCAs were not aware of the trust's overall vision.

Culture within the service

- Staff on Ward 8 (MAU) told us that the team was "close knit" and morale was very good. Staff worked well together towards achieving positive outcomes for patients. Nurses said that morale had improved since the summer as there were more permanent staff.
- Some HCAs did "not feel valued" and felt that there were few opportunities for career progression.
- Pharmacy technicians felt well supported and that their service was forward-thinking.
- Some staff reported an improvement in staff morale over the last few months. However, some staff reported feeling pressurised and said that keeping morale up was "a struggle", especially when staff were asked to work on wards that they were unaccustomed to working on.

- Most staff reported an improvement in effective communication to and from the trust's board.
- Some support staff felt that work pressure had increased, as the workload was rising due to the increasing dependency of patients.
- Some staff were concerned about the longer-term future of the acute service offered by the hospital, as the hospital had stopped providing a hyper-acute stroke service. This had affected staff morale on the stroke ward and staff on this ward were not fully aware of the longer-term plans for the stroke service.
- Staff generally were very positive about team working on their wards.
- Some wards reported a higher than average sickness absence rate; this was usually due to the impact of having staff absent on long-term sick leave. Ward leaders told us of the trust's more robust approach to supporting staff with attendance issues. The hospital had a sickness absence rate of 4.79% for October 2014, which was slightly worse than the trust target of 4.44%.
- Ward leaders were very positive, and spoke very well of support from senior managers.

Public and staff engagement

- Wards displayed performance boards that showed the patients' feedback responses for the previous month. Ward 7 had an average score of 4.5 stars (out of five stars) for November 2014 and had a response rate of 22.8% of eligible patients. However, these performance boards did not have the month or date displayed; staff said that they always related to the previous month.
- Ward 3 had an average score of 4.71 stars with a response rate of 64.6% of eligible patients.
- The monthly board meetings included a patient story to highlight patients' experiences of using the hospital's services.
- Some people told us that having the board meeting minutes available to the public online helped them understand more about the hospital and how it was performing.
- Feedback from patients was regularly sought, and results displayed in ward areas.

Innovation, improvement and sustainability

- Innovation was encouraged, but staff told us that they were not always able to recommend changes due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, while others did not.
- Senior staff said that the service was not well supported in terms of information technology and hospital informatics data and that this was hindering innovation and the redesign of services.
- Ward leaders felt confident about managing the pace of change if it were carried out in a planned fashion.
- Staff generally had objectives that focused on improvement and learning as part of their appraisals.
- We saw that innovation was supported on Ward 8 and a consultant showed us examples of changes to working practices to improve outcomes for patients. One example was the way in which the staff team had set up designated roles for certain staff members to carry out urgent treatment for patients having cardiac arrests. Ward staff wore lanyards to show what role they would play in the event of such an emergency. Other ward staff would continue to supervise the other patients and only the designated cardiac arrest team would respond to the emergency. This ensured that all patients received appropriate levels of support while the dedicated team dealt with the emergency. The ward had also set up a simple but effective checklist system for recording when blood tests were due and were taken by phlebotomists. This meant that doctors and nurses knew when test results were due to be taken and the results received.
- The hospital had just commenced a sleep clinic in outpatients to look at the best management plans for patients with sleep apnoea.

Surgery

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

Information about the service

We carried out a visit as part of our announced inspection on 9 December 2014. The surgical wards and operating theatres were all based at Macclesfield District General Hospital (MDGH). A range of surgical services were provided from the hospital including oral surgery, breast surgery, ear, nose and throat (ENT) surgery, trauma and orthopaedics, ophthalmology, urology and general surgery (such as colorectal surgery).

There were five surgical wards and seven theatres that carried out elective orthopaedic surgery, day surgery and emergency surgery procedures. One of the theatres was not in use. As part of the inspection, we inspected the main theatres, orthopaedic theatres, day case unit, endoscopy unit, surgical assessment lounge (SAL), preoperative assessment unit, ward 1 (general surgical ward), ward 1A (female surgical ward), ward 5 (trauma and orthopaedic ward) and ward 6 (elective orthopaedic ward).

We spoke with 12 patients. We observed care and treatment and looked at seven care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, the matron, clinical directors and the head of service for surgical specialties. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital.

Summary of findings

Older equipment, such as operating tables used in theatres, was not replaced in line with manufacturers' recommendations. During our inspection we raised this issue with the trust. We reviewed what action the trust had taken during our unannounced visit and found that it had taken action to address our concerns. The general environment within the day case and main operating theatres was not maintained suitably. We raised concerns regarding specific environmental issues during the inspection. The trust took immediate action to address our concerns. Staff received mandatory training. However, clinical mandatory training compliance was below the hospital's target of 80%. Medicines were stored safely and given to patients in a timely manner. Where patients received oxygen treatment, the use of oxygen was not always recorded on medication charts. The majority of staff followed infection prevention and control guidelines but policies for managing patients in isolation rooms were not always followed.

Patients experienced delayed transfers of care to other providers, such as community intermediate care. The surgical services had clear plans in place for how they would reduce delayed transfers of care. The hip fracture audit for 2013 showed that the hospital's performance was worse than the England average for the percentage of patients undergoing hip surgery within 36 hours and within 48 hours. The clinical director for orthopaedics told us that they had increased the number of patients

with hip fractures who underwent surgery within 36 hours over the past year and the improved performance would be reflected in the hip fracture audit data for 2014. The surgical services met the national targets for 18-week referral-to-treatment times (RTT) for patients admitted for general surgery but following a national amnesty agreed by NHS England and the Trust Development Authority, failed to meet the national targets for all other specialties. The theatres department did not always meet its own performance targets, which meant that theatre lists did not always start or finish at the required times. All patients whose operation was cancelled were treated within 28 days. The average length of stay for elective and non-elective patients across all specialties was longer than the England average. The surgical services had taken action to improve the length of stay for patients undergoing elective hip and knee surgery by using rapid recovery care pathways.

There were action plans in place to address identified risks. However, we found that when issues were identified, timely action was not always taken to address those risks. The theatres department had not had a theatre manager since December 2013. The theatres were managed by two theatre leads who were band 7 nurses. The theatre leads reported to the head of service for surgical specialties and were responsible for the day-to-day management of the theatres department.

The majority of staff were positive about the culture and support available across the surgical services. Patient safety was monitored and incidents were investigated to assist learning and to improve care. The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. Patients received care and treatment by trained, competent staff who worked well as part of a multidisciplinary team (MDT). Patients spoke positively about their care and treatment. Patients were treated with dignity and received compassionate care.

Are surgery services safe?

Requires improvement

Older equipment, such as operating tables used in theatres, was not replaced in line with manufacturers' recommendations. During our inspection we raised this issue with the trust. We reviewed what action the trust had taken during our unannounced visit and found that it had taken action to address our concerns. The general environment within the day case and main operating theatres was not maintained suitably. During the inspection we raised concerns regarding a damaged wall in the day case theatre. The trust took immediate action to address our concerns. We also found a shower room where the edges around the floor were not sealed, allowing water to get between the wall and the floor covering. An infection control audit report for ward 1 showed that this had been identified in August 2014 but no remedial action had been taken. This was raised with staff and the edges were sealed by the maintenance team during the inspection.

Staff received mandatory training in order to provide safe and effective care. However, the number of surgical staff who had completed clinical mandatory training was below the hospital's target of 80%. Medicines were stored safely and given to patients in a timely manner. Where patients received oxygen treatment, the use of oxygen was not always recorded on medication charts. The majority of staff followed infection prevention and control guidelines but policies for managing patients in isolation rooms were not always followed.

Patient safety was monitored and incidents were investigated to assist learning and to improve care. Patient records were completed appropriately. The staffing levels and skill mix were sufficient to meet patients' needs and staff assessed and responded to patient risks.

Incidents

- The Strategic Executive Information System (STEIS) data showed that there had been four serious incidents reported in relation to surgical services at the hospital during 2013/14. Three of these were for patients acquiring grade 3 pressure ulcers and one was for a

patient who acquired a grade 4 pressure ulcer. During the inspection, we saw evidence that these incidents had been investigated and remedial actions implemented to improve patient care.

- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the hospital-wide electronic incident-reporting system. Complaints were also logged on the electronic incident-reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by senior staff with the appropriate level of seniority.
- Information relating to lessons learned from incidents, such as medication errors, were displayed on noticeboards in all the areas we inspected. Ward staff told us that incidents were also discussed during routine staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at. However, the theatre staff told us that they did not always get feedback following incidents that were reported.
- There were no mortality outliers within the surgical services. Patient mortality and morbidity were reviewed by individual consultants within their surgical specialty area and reviewed at monthly clinical audit meetings within each specialty. Patient mortality was also reviewed at hospital-wide mortality group meetings and outcomes were reported to the trust board.

Safety thermometer

- NHS safety thermometer information for July 2013 to June 2014 showed that the number of patients with falls with harm, catheter urinary tract infections (CUTIs) and new pressure ulcers varied each month with no clear trends.
- The matron for surgical specialties and ward managers could not attribute the numbers of falls, CUTIs or pressure ulcers to any specific factors. Patient records showed that appropriate risk assessments were carried out upon admission to the wards and patients identified as being at risk had the appropriate care plans and supporting equipment (e.g. pressure-relieving mattresses) in place to minimise the risk of patient harm.
- We saw that noticeboards near the entrance to ward areas displayed the number of patients with falls and pressure ulcers during the current month. However, information relating to CUTIs was not visibly displayed within the wards or theatre areas we inspected.

Cleanliness, infection control and hygiene

- There were no cases of methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections but there were two cases of Clostridium difficile (C. difficile) infections in the surgical wards and theatres between April 2014 and November 2014. These occurred in May 2014 on ward 1 (general surgical ward) and in June 2014 on ward 1A (female general surgical ward).
- Each C. difficile incident was investigated to identify the root cause. We looked at the investigation report and action plans for a C. difficile incident on ward 1 and saw that this was investigated appropriately and there was clear involvement from nursing and clinical staff, as well as the hospital's infection control team.
- Hospital data for surgical site infections (SSIs) following hip replacement surgery, repair to neck of femur and large bowel surgery showed that there had been a continual reduction in the number of infections between July 2013 and June 2014. For example, there had been no infections reported following hip replacement surgery since January 2014, whereas there had been 10 infections reported between July 2013 and December 2013.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a sufficient number of hand-washing sinks and hand gels. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- The majority of staff we observed followed hand hygiene and 'bare below the elbow' guidance. We observed two instances where medical staff did not wash or gel their hands when entering the surgical wards and providing care to patients. Ward nurses told us that they would challenge other staff and visitors to the wards if they saw hand hygiene guidelines not being

adhered to. There was a monthly hand hygiene audit across the surgical wards and theatres. Hospital data for April 2014 to October 2014 showed a high level of hand hygiene compliance among staff.

- Gowning procedures were adhered to in the theatre areas. Staff used reusable gowns and surgical drapes in the theatre areas. The clinical director for surgical services told us that they planned to trial the use of single-use gowns and drapes in January 2015 for use by all theatre staff.
- Patients identified with an infection were isolated in side rooms and we saw that appropriate signage was in use to protect staff and visitors. However, on ward 1 we saw that the doors to two isolation rooms were kept open when the patients had been identified as an infection risk. This was raised with the ward staff during the inspection and the issue was addressed immediately.

Environment and equipment

- Ward 5 (trauma and orthopaedic ward) had only one shower room that was fit for purpose. The remaining en-suite rooms and bathrooms were equipped with baths, making them difficult for patients to use.
- The ward manager told us that they did not use these facilities for bathing patients and either used the shower room on the ward or used the facilities on nearby ward 6 (elective orthopaedic ward), which had been refurbished with wet rooms. Ward 5 was scheduled for refurbishment by April 2015 and the refurbishment plan included the installation of wet rooms to replace the existing baths.
- Ward 1 (general surgical ward) had a shower room where the edges of the floor were not sealed allowing water to get between the wall and the floor covering. An infection control audit report for ward 1 showed that this had been identified in August 2014 but no remedial action had been taken. This was raised with staff and the edges were sealed by the maintenance team during the inspection.
- The orthopaedic theatres were clean and well maintained. All the theatre areas were free from clutter and we saw that equipment and consumable items were stored appropriately.
- The day case and main theatre areas were not well maintained. Within the day case theatre, we found that a small section of wall had been damaged and had a hole with exposed plaster. The main theatres also had cupboard doors that were damaged and sections where walls were marked or had paint peeling off. Within the corridor area, we saw screw holes left in a wall after the removal of a sign or noticeboard. The wear and tear of the general environment within the theatres meant that there was a potential infection control risk because the sections with exposed plaster may not be appropriately cleaned or decontaminated.
- There was a scheduled refurbishment programme in place for the theatres that was due for completion in October 2016.
- The majority of equipment we observed in the wards and theatre areas was clean, safe and well maintained. However, we found that two out of the six operating tables in use were manually operated and these had been identified as needing replacement. Within the past 12 months, there had been one incident reported in November 2014 relating to excess play in one of the identified operating tables; however, there was no patient harm reported. The manually operated operating tables were listed on the surgical risk register and remedial actions included the delivery of replacement operating tables by 16 December 2014.
- Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- Staff told us that they used single-patient-use, sterile instruments where possible. The single-use instruments we saw were within their expiry dates.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit. Theatre staff told us that they had access to the equipment they needed to meet patients' needs.
- The hospital provided a day case endoscopy service. Reusable endoscopes (used to examine the interior of a hollow organ or cavity in the body) were cleaned and decontaminated in a decontamination room accredited by the joint advisory group (JAG) for gastrointestinal endoscopy.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were stored securely in locked cabinets.

- Staff also carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly. There was also a weekly medication audit carried out by a pharmacy technician.
- We found that medicines were ordered, stored and discarded in a safe and appropriate manner.
- Medical staff were aware of the policy for prescribing antimicrobial medicines. Trust data showed that antimicrobial prescribing 'stop and review' date performance was reviewed on a monthly basis and that there was a high level of compliance across the surgical wards.
- We saw that medicines that required storage at temperatures below 8ºC were stored appropriately in medicine fridges. Fridge temperatures were checked daily to ensure that medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed that a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for five patients and found these to be complete, up to date and reviewed on a regular basis. We saw that antimicrobial prescribing stop and review dates were completed and reasons for any medicines not given were documented clearly. Medicines given to patients 'as required' had minimum and maximum doses recorded.
- However, we spoke with a senior house officer (SHO) who told us that oxygen treatment for patients should be prescribed and documented. The medication charts included a section for prescribing oxygen and we identified three patients on the surgical wards who had received oxygen treatment but this had not been documented on their medication charts.

Records

- Staff used paper-based patient records and these were securely stored in each area we inspected.
- We looked at the records for seven patients. The medical and nursing notes were structured, legible, complete and up to date.
- Patient records included risk assessments, for example for patient falls, venous thromboembolism (VTE), pressure care or nutrition, and these were completed correctly and reviewed at least weekly.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children.
- Staff were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was displayed in each area we inspected.
- The wards and theatres also had safeguarding link nurses in place. Staff told us that they could contact the hospital-wide safeguarding lead if they required additional guidance or support.

Mandatory training

- Mandatory training for staff in the surgical services was delivered in two parts. Staff received annual core statutory mandatory training by e-learning and clinical mandatory training via face-to-face and practical training.
- The mandatory training covered key topics such as infection control, information governance, equality and diversity, fire safety, safeguarding children and vulnerable adults, manual handling and resuscitation training.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- Hospital data up to December 2014 showed that the majority of staff across the surgical wards and theatres had completed their core statutory mandatory training (e-learning); the completion rate was above the hospital's internal target of 89%.
- However, data showed that the hospital's internal target of 80% compliance in clinical mandatory training had not been achieved across any of the surgical wards or theatres. The completion rate for the various staff groups within the wards and theatres ranged from 39% to 75%, which meant that there was inconsistency in the completion of clinical mandatory training.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the matron to address these risks.

- Upon admission to the surgical wards and prior to undergoing surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for VTE, pressure ulcers, nutritional needs, risk of falls and infection control risks. Patients identified as being at high risk were placed on care pathways. Care plans were in place to ensure that risks were mitigated and patients received the right level of care.
- Ward staff used an electronic system on handheld devices for monitoring all patient observations, including nutrition and hydration. The system calculated early warning scores (EWS) and alerted staff if patients' clinical observations were out of the normal range.
- Staff carried out 'intentional rounding' observations every two hours and this increased to hourly checks if there was a deterioration in the patient's medical condition.
- Where a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff carried out an audit to monitor adherence to the WHO checklist by reviewing the completed checklist record.

Nursing staffing

- The matron for surgical specialties told us that staffing levels were monitored against minimum compliance standards using an acuity tool and that this was reviewed every six months. Information on staffing levels, including actual versus establishment, was clearly displayed near the entrance to the ward and theatre areas and this information was updated daily.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us that staffing levels were based on the dependency of patients and that this was reviewed daily. We saw that staffing levels on the wards were increased so patients needing one-to-one care could be supported appropriately.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff. However, staffing levels were maintained with the use of bank and agency staff. The head of service for surgical specialties told us that the majority of agency staff working in the theatres were regular agency staff who had undergone induction training and were familiar with the theatres department's policies and procedures.
- The ward managers told us that they tried to use regular bank or agency staff and ensured that temporary staff were accompanied by permanent trained staff where possible, so that patients received an appropriate level of care. Agency staff underwent induction and checks were carried out to ensure that they had completed mandatory training prior to commencing employment.
- Hospital data from December 2014 showed that there were six whole-time equivalent (WTE) nursing vacancies on ward 6 (elective orthopaedic ward) along with nine WTE nursing and 10 WTE untrained staff vacancies on ward 2 (day case and winter escalation ward). The staffing shortfall on ward 2 was because 15 additional escalation beds were in place until April 2015 as part of the winter escalation plan; bank and agency staff were used to maintain safe staffing levels.
- The ward managers and matron for surgical specialties had identified where the ward staffing shortfalls were and they were in the process of recruiting additional staff to fill these vacancies.
- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues. The ward staff also carried out safety briefs during the handover meetings to discuss patients with specific needs, such as patients with learning difficulties, dementia or pressure ulcers or patients at risk of falls.

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care.
- NHS workforce statistics data from September 2013 showed that the proportion of middle-career doctors (e.g. SHOs) within the surgical services was 33% compared with the England average of 11%. The ratio of junior doctors was also greater than the England average (19% compared with an average of 13%). The

ratio of consultants was 33% compared with the England average of 40%. The ratio of registrars was also below the England average (13% compared with an average of 37%).

- The clinical director for surgical services and the head of service for surgical specialties told us that middle-career doctors at the hospital were experienced so they were able to meet patient needs effectively. They also told us that they planned to promote middle-grade doctors to consultant posts due to difficulties in recruiting suitable candidates.
- The head of service for surgical specialties told us that they had identified areas where additional recruitment was needed and planned to recruit two consultants, including one replacement post for a colorectal surgeon. A consultant interview for one of these posts was scheduled for January 2015.
- We found that surgical consultants from all specialties were on call over a 24-hour period and there was sufficient medical cover out of hours and at weekends.
- Locum doctors were used to cover for existing vacancies and to provide cover for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure that they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes. These were consultant-led and included discussions about specific patient needs.

Major incident awareness and training

- Staff received mandatory training in resuscitation and had clear instructions for dealing with medical emergencies such as a patient going into cardiac arrest.
- There was a documented major incident plan and business continuity plan within the surgical services that 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.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with services in similar-sized hospitals and performed in line with the England average for most safety and clinical performance measures.

Patients received care and treatment by trained, competent staff who worked well as part of an MDT. Staff sought consent from patients prior to delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS).

The majority of patients had a positive outcome following their care and treatment. However, the average length of stay for elective and non-elective patients across all specialties was longer than the England average. The surgical services had taken action to improve the length of stay for patients undergoing elective hip and knee surgery by using rapid recovery care pathways.

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included the monitoring of guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.
- Staff provided care in line with NICE clinical guideline 50 (Recognition of and response to acute illness in adults in hospital) as well as the critical illness rehabilitation (CG83) guidance.
- Staff in the surgical wards used enhanced care and rapid recovery pathways, in line with national guidance. The neck of femur care pathway included the Nottingham Hip Fracture Score (NHFS) and staff used this to predict patient outcomes after hip fracture surgery.
- Findings from clinical audits conducted in the surgical services were reviewed at monthly clinical audit meetings and any changes to guidance along with the impact these would have on staff practice were discussed.
- Nursing and medical staff told us that policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet.
- We looked at 11 policies and procedures on the hospital's intranet; these were up to date and reflected national guidelines. However, we found one guideline document for use by the medical staff in the surgical wards that was last reviewed in 2009.

Surgery

Pain relief

- Patients were assessed preoperatively for their preferred post-operative pain relief. Staff monitored patient symptoms using a pain assessment score and carried out 'intentional rounding' observations at two-hourly intervals to identify patients who required pain relief.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients spoke positively about the way in which staff managed their pain relief symptoms and said that staff gave them pain medication in a timely manner.
- The nursing staff told us that they could access a pain specialist nurse if they needed additional support or guidance. The pain control nurse told us that they monitored the use of pain team referrals and also intervened in the care of all patients undergoing major surgery, including general surgery and orthopaedics.

Nutrition and hydration

- The patient records we looked at included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Where patients were identified as being at risk, there were fluid and food charts in place. These were reviewed and updated by staff.
- Where patients had a poor intake of food, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement where patients were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used the red tray system so that patients living with dementia could be identified and supported by staff during mealtimes.
- The majority of patients we spoke with told us that they were offered a choice of food and drink and spoke positively about the quality and portion size of the food offered.

Patient outcomes

- There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit.
- The national bowel cancer audit for 2013 showed that the trust was performing better than the England average for case ascertainment, the number of patients who had a computerised tomography (CT) scan, the number of cases discussed at MDT meetings and the number of patients seen by a clinical nurse specialist.
- The national bowel cancer audit also showed that the trust was worse than the England average for data completeness (72% compared with the England average of 79%) and for patients with a length of stay over five days (73% compared with an average of 68.9%).
- The lung cancer audit for 2012 showed that the trust performed better than the national average for the number of cases discussed at MDT meetings (100% compared with the England and Wales average of 95.6%) and the percentage of patients receiving CT before bronchoscopy (95.4% compared with the England and Wales average of 89.5%).
- The national hip fracture audit for 2013 showed that the hospital's performance was better than the England average for ascertainment rate, percentage of patients admitted to orthopaedic care within four hours, preoperative assessment by an orthopaedic geriatrician, patients developing pressure ulcers and patients undergoing falls and bone health medication assessments. The hospital's performance was worse than the England average for mean total length of stay (26% compared with an average of 19.2%).
- The clinical director for surgical services and the head of service for surgical specialties told us that performance against national audits was routinely monitored to improve services.
- Hospital episode statistics (HES) 2013/14 data showed that the average length of stay for elective and non-elective patients across all specialties was longer than the England average.
- The head of service for surgical specialties could not attribute the average length of stay performance to any specific factors but told us that the introduction of rapid recovery care pathways had led to reductions in the length of stay for elective orthopaedic patients.
- Information displayed on ward 6 (elective orthopaedic ward) showed that an audit had been carried out on patient length of stay based on a sample of 250 patients undergoing elective hip and knee surgery. The data showed that the implementation of the rapid recovery care pathway had reduced the length of stay from 6.5 days to 4.5 days following hip surgery and from 6.5 days to 3.6 days following knee surgery.

- Performance Reported Outcome Measures (PROM) data for April 2013 to December 2013 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was either similar or better than the England average.
- HES 2013/14 data showed that the number of patients who underwent elective and non-elective surgery and were readmitted to hospital following discharge was lower (better) than the England average for all specialties except elective ophthalmology.
- Hospital data for October 2013 to November 2014 showed that 31 patients had been readmitted to the hospital after undergoing ophthalmology surgery; however, only two of these readmissions were for conditions relating to ophthalmology. The other 29 readmissions were for other non-related health conditions.
- The head of service for surgical specialties also told us that some intraocular injection (injection in the eye) treatments required patients to attend the hospital once a month over a three-month period and this had an impact on the hospital's readmission data for ophthalmology.
- HES 2013/14 data showed that day surgery rates (the percentage of patients admitted for a surgical procedure and discharged the same day) across all specialties at the hospital were in line with acceptable standards.
- The national emergency laparotomy audit (NELA) report from May 2014 showed that 17 of the 31 standards were available at the trust. The audit highlighted that the hospital did not have a dedicated surgical assessment unit and that fully staffed operating theatres were not available for emergency general surgery patients 24 hours a day, seven days a week.

Competent staff

- Newly appointed staff underwent an induction process and their competency was assessed prior to working unsupervised. Agency and locum staff also underwent recruitment checks and induction training prior to commencing employment.
- Trust data up to August 2014 showed that 93% of staff in the surgical specialties had completed their annual appraisals. However, the data also showed that only 30% of staff in the theatres had completed annual appraisals.
- Consultants underwent peer appraisals and were overseen by the associate medical director, who was the responsible officer. The medical staff we spoke with did not highlight any concerns relating to appraisal and revalidation. Records showed 94% of medical staff appraisals had been completed by November 2014.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us that they were supported well by their line management.

Multidisciplinary working

- There was daily communication between MDTs within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure that all staff had up-to-date information about risks and concerns.
- The ward staff we spoke with told us that they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. MDT meetings took place three times per week on ward 5 (trauma and orthopaedic ward) and ward 6 (elective orthopaedic ward) and these were attended by medical, nursing and surgical staff as well as allied health professionals (such as physiotherapists).
- The patient records we looked at showed that there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff we spoke with told us that they received good support from pharmacists, dieticians, physiotherapists, occupational therapists and social workers as well as diagnostic support such as for x-rays and scans.
- The head of service for surgical specialties told us that there was multidisciplinary working with four general practitioner (GP) clinics so they could carry out diagnostic tests in the community prior to elective patients being admitted to hospital for general surgery.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained out of hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle-grade doctors as well as by on-site and on-call

consultant cover. Newly admitted patients were seen by a consultant at the weekends. Existing patients on the surgical wards were seen by the registrar during the weekends.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on call out of hours and at weekends. The dispensary was also open until 1pm on Saturdays and Sundays.
- The ward and theatre staff told us that they received good support out of hours and at weekends.
- Within the theatres, staff were on call at weekends so that any patients admitted over the weekend who required emergency surgery could be operated on.

Access to information

- The hospital used paper-based patient records. The patient records we looked at were complete, up to date and easy to follow. The records we looked at contained detailed patient information from admission and surgery through to discharge within the patient record. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- Discharge letters given to patients and sent to GPs were written by the doctors and included all the relevant clinical information relating to the patient's stay at the hospital.
- The staff we spoke with told us that information about patients was easily accessible.
- We saw that information such as staffing levels, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.
- Staff attended weekly 'keep in touch' briefings and monthly team meetings so information could be cascaded to staff in a timely manner.
- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- The nursing and medical staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought verbal informed consent and written consent before providing care or treatment.
- Patient records showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- The staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and DoLS.
- Where patients lacked the capacity to make their own decisions, staff told us that they sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the hospital's 'best interests decision-making policy'.
- Patient records for two patients living with dementia showed that consent forms had been signed by a junior doctor and countersigned by the consultant. The records also showed that staff had carried out discussions with the relatives of both patients.
- Patient records showed that doctors used the abbreviated mental test (AMTS) score to identify patients who lacked capacity. A junior doctor told us that they used the AMTS score to assess all patients over the age of 70 years and that the AMTS score was also repeated after the patient underwent surgery.
- There was a hospital-wide DoLS team that provided support and guidance for staff on mental capacity assessments, best interest meetings and DoLS applications.
- The DoLS team coordinated patient assessments across the hospital and notified the ward managers about patients with active DoLS orders on a weekly basis. Patient records showed that ward staff used a DoLS care plan that provided additional guidance and instructions on how to care for patients with DoLS in place.

Are surgery services caring?

Good

Patients spoke positively about their care and treatment. Patients were treated with dignity and received compassionate care. Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs and there were bereavement services in place to provide support for patients, relatives and staff.

Surgery

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that curtains were drawn in the ward bays to ensure that patients' privacy and dignity were maintained.
- During the inspection, we spoke with 12 patients. All the patients we spoke with said that they thought staff were kind and caring and gave us positive feedback about the ways in which staff showed them respect and ensured that their dignity was maintained. Patients told us that the care and treatment they received were timely and of a good standard.
- We received negative feedback from one patient on ward 6 (elective orthopaedic ward) relating to disruption and noise at night. This was discussed with the ward manager during the inspection who told us they would look at how this could be improved.
- The NHS Friends and Family Test (FFT) data for April 2013 to July 2014 showed all the surgical wards consistently scored better than the England average, indicating a positive response from patients about whether they would recommend the hospital's wards to friends and family.
- The average FFT response rates were worse than the England average across the surgical wards.
- The matron for surgical specialties told us that response rates were monitored and discussed at monthly meetings to raise staff awareness. In order to improve response rates, the Friends and Family Test had been added to the nurses' discharge checklist to prompt staff during patient discharges.
- A review of the data from the CQC's adult inpatient survey for 2013 showed that the trust was about the same in comparison with other trusts for all 10 sections.

Understanding and involvement of patients and those close to them

- Staff respected patients' right to make choices about their care. We observed staff speaking with patients clearly and in a way they could understand.
- The patient records we looked at included pre-admission and preoperative assessments that took into account individual patient preferences and records of discussions with patients' relatives.
- The patients we spoke with told us that they were kept informed about their treatment. Patients spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- We saw that medical ward rounds occurred on a daily basis and included input from the nursing staff and other health professionals, such as physiotherapists and social workers if needed.
- During a ward round we observed that a consultant took time to explain to the patients their problems and plans for treatment.

Emotional support

- Staff understood the importance of providing patients with emotional support. The patients we spoke with told us that they were supported with their emotional needs. One patient told us they experienced anxiety following surgery and the ward staff were helpful and supportive.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services. Patients were also provided with a bereavement booklet.
- Staff told us that they could access the hospital's palliative (end of life care) team and the bereavement team for support and advice during bereavement.

Are surgery services responsive?

Requires improvement

Patients experienced delayed transfers of care to other providers, such as community intermediate care or nursing homes. The surgical services had clear plans in place for how they would reduce delayed transfers of care.

The hip fracture audit for 2013 showed that the hospital's performance was worse than the England average for the percentage of patients undergoing hip surgery within 36 hours (70.3% compared with an average of 73.4%) and within 48 hours (83.4% compared with an average of 87.3%). The clinical director for orthopaedics told us that

they had increased the number of patients with hip fractures who underwent surgery within 36 hours over the past year and the improved performance would be reflected in the hip fracture audit data for 2014.

The surgical services met the national targets for 18-week RTT for patients admitted for general surgery but following an agreed national amnesty by NHS England and the Trust Development Authority, failed to meet the national targets for all other specialties. The theatres department did not always meet its own performance targets, which meant that theatre lists did not always start or finish at the required times. All patients whose operation was cancelled were treated within 28 days.

The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included oral surgery, breast surgery, ENT surgery, trauma and orthopaedics, ophthalmology, urology and general surgery (such as colorectal surgery and upper gastrointestinal surgery).
- HES 2013/14 data showed that 15,321 patients were admitted for surgery at the hospital. The number of patients admitted was the tenth lowest number in comparison to other trusts in England.
- HES 2013/14 data showed that 64% of patients underwent day case procedures, 12% underwent elective surgery and 24% were emergency surgical patients.
- There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital.
- There was routine engagement and collaboration with staff from these hospitals, such as on-site outpatient clinics and MDT meetings for vascular and ENT services where outpatient clinics were carried out by visiting consultants.
- The hospital also provided breast screening and some breast surgery services for patients from a neighbouring hospital.
- The hospital had a total of seven operating theatres, consisting of four main theatres, two orthopaedic theatres and one day case theatre. One of the theatres in the main theatre suite was permanently closed and was being used as a storage area. The hospital carried out elective orthopaedic, oral and ophthalmology surgery on Saturdays.
- The hospital ran a scheduled list for emergency procedures between 9am and 12pm daily. Patients undergoing surgery for traumatic injuries were scheduled between 12.30pm and 5pm. There was an on-call team so that patients admitted to the hospital who required emergency surgery out of hours and at weekends could be operated on in a timely manner.
- Emergency surgery took place under National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) guidelines; however, a consultant anaesthetist was not always present.
- The hospital did not have a surgical assessment unit. All patients admitted via the emergency department were seen by a doctor and transferred directly to a surgical ward.

Access and flow

- During the inspection, the patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patients undergoing day surgery were given morning or afternoon appointment times. The patients and staff we spoke with told us that patients were treated in a timely manner and patients did not experience extended waiting times.
- Patients undergoing elective surgery were admitted to the hospital via a surgical admissions lounge (SAL), which operated between 7am and 5pm, Monday to Friday. The SAL had a waiting area that could accommodate up to 14 people and had three treatment rooms, where patients were assessed by a surgeon and anaesthetist prior to undergoing surgery.
- Patients in the SAL waiting area had access to television and magazines. Patients waiting in the SAL and the preoperative assessment unit were also given the choice to leave the waiting areas and go to other parts of the hospital (such as the shop or restaurant areas). The staff were able to provide patients with an electronic 'coaster' paging device so that they could be contacted when their appointment was due. Patients and staff spoke positively about this system.
- Patient records showed that discharge planning took place at an early stage and there was multidisciplinary

input (e.g. from physiotherapists). Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure that patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.

- Upon discharge, patients were either transferred to a discharge lounge or discharged directly from the wards, so staff could continue to monitor them during their wait. Staff aimed to get patients 'home for lunch' on the day of the discharge. We saw that, where this was not possible, the reasons for delay were reviewed by the ward managers.
- Ward staff told us that the majority of patient delays were due to delayed transfers of care. Hospital data for March 2014 to October 2014 showed that there had been a total of 1,442 patients with delayed transfers of care across the hospital. The most frequent reasons for delays were 'overview document not completed', 'awaiting intermediate care placement' and 'patient or family selecting nursing/rest home'. There was an action plan in place to improve delayed transfers of care that included specific actions, such as the implementation of a multi-agency strategy group and the additional recruitment and training of hospital and community-based staff.
- NHS England data showed that the overall hospital-wide bed occupancy rate between April 2013 and June 2014 ranged between 86% and 91%. The high level of bed occupancy was reflected in the surgical wards, as we found that all available beds were occupied. Bed occupancy was monitored on a daily basis and patients could be transferred to other surgical wards if no beds were available within a specific surgical specialty.
- There was a winter pressures escalation plan in place. Ward 2 (day case ward) had six day case beds but was being used as a designated escalation ward with an additional 15 inpatient beds until March 2015. The additional beds consisted of 15 medical and six surgical inpatient beds.
- Ward 5 (trauma and orthopaedic ward) also had six additional escalation beds that were being used for medical patients until March 2015. Staff told us that these patients were routinely seen by doctors from within the medicine specialties. Surgical patients who were not situated within their specialty ward (surgical outliers) were seen by surgical doctors on a daily basis.
- There was sufficient bed space in the theatres to ensure that patients could be appropriately cared for before and after their operation. There was a designated intensive care recovery bay in the main theatres for critically ill patients who required stabilisation prior to transfer to the critical care unit (CCU).
- NHS England data for April 2013 to June 2014 showed that national targets for 18-week RTT standards for admitted patients were met for patients undergoing general surgery. However, the performance against RTT standards for ENT, urology, ophthalmology, oral surgery and orthopaedics and trauma ranged between 84% and 88% during this period, which meant that the hospital was not meeting the waiting time target of 90% for these specialties. There was a national amnesty for July, August, September and October 2013 agreed by the Trust Development Authority and NHS England to increase volume of 18 week RTT to reduce backlog. This meant achievement of the national target was not mandated during this period.
- The head of service for surgical specialties told us that performance against RTT standards for each specialty was monitored on a weekly basis. This included reviewing additional capacity for surgery at the hospital and referral to external hospitals for patients awaiting surgery. Whilst there was no specific action plan in place to improve RTT standards, a spreadsheet was generated each week in order to prioritise patients that were coming up to 18 weeks.
- The head of service said this is something that was introduced recently to improve RTT performance but it's unclear how effective this process is until it's been in place for a while
- NHS England data showed that the number of elective operations cancelled was lower (better) than the England average between April 2014 and September 2014.
- Hospital data showed that there had been a total of 442 operations cancelled at the hospital between April 2014 and November 2014. The most frequent reasons for cancellations were 'emergencies taking priority' (27%), 'consultant not available' (17%) and 'no beds available' (17%).

Surgery

- Hospital data showed that there had been a total of 82 operations cancelled on the day of surgery between April 2014 and November 2014. The most frequent reasons for cancellations were 'no beds available' (44%) and 'ran out of theatre time' (24%).
- NHS England data showed that, since June 2012, all patients whose operation was cancelled were treated within 28 days. The head of service for surgical specialties told us that staff arranged a new date with the patient on the day of the cancellation.
- The hip fracture audit for 2013 showed that the hospital's performance was worse than the England average for the percentage of patients undergoing hip surgery within 36 hours (70.3% compared with an average of 73.4%) and within 48 hours (83.4% compared with an average of 87.3%).
- The clinical director for orthopaedics told us that they had increased the number of patients with hip fractures who underwent surgery within 36 hours over the past year. Discussions with staff indicated this had been done through better planning and more focussed MDT meetings. For example, ensuring theatre space was available for patients in advance as this was elective surgery and improved monitoring of patient flow so bed capacity 'bottle necks' could be identified quickly. They also introduced rapid recovery pathways to ease capacity by improving discharges. No specific data was available at the time of our inspection to determine the impact these changes had made. The clinical director for orthopaedics told us the improved performance would be reflected in the hip fracture audit data for 2014.
- The hospital had four performance targets relating to theatre utilisation. Hospital data for April 2014 to November 2014 showed that the theatres department was meeting two out of the four internal targets across all specialties. These were for 'overall utilisation of planned theatre lists' and for 'patient operating hours as a percentage of anaesthetic and surgical time'.
- The data showed that the theatres department was slightly below its target for 'actual run time of lists as a percentage of their session planned hours' (86% compared with a target of 90%) and slightly below the target for 'end utilisation of the original planned hours' (75% compared with a target of 77%) during this time period.
- The theatre staff we spoke with told us that theatre lists frequently started late and overran. Hospital data showed that of the total 1,381 lists run between April 2014 and November 2014, only 378 (27%) were run on time, 623 (45%) finished more than 30 minutes early and 171 (12%) finished later than 30 minutes behind the scheduled time.
- The head of service for surgical specialties told us that they did not hold routine theatre utilisation group meetings because patient scheduling and theatre performance were managed on the theatres department's electronic system on a daily basis.
- The surgical services service line objectives for 2014/15 outlined the theatres department's targets for theatre utilisation and performance against 18-week RTT standards and included actions to improve theatre utilisation. However, the theatre utilisation and 18-week RTT data we looked at showed that the theatres department did not always meet its own performance targets.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us that they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia awareness. Patients living with dementia were identified using a blue flower symbol.
- Ward 5 (trauma and orthopaedic ward) had an area designated for patients living with dementia. Where a patient was identified as having dementia or learning disabilities, staff provided one-to-one care and participated in activities with the patient. For example, we observed a member of staff playing a board game with a patient on ward 5; the patient appeared happy and settled.
- Where staff were unable to communicate with patients, they could access communication cards that included easy-to-follow visual prompts. Ward staff also discussed patient needs with relatives or carers and these discussions were documented in the patient records we looked at.
- Ward staff told us that they applied 'reasonable adjustment' principles for patients with learning disabilities and we saw that specific care plans and risk assessments were in place to provide guidance for staff on how to care for patients with learning disabilities such as autism.

- The hospital had leads in place for certain patient conditions. For example, the matron for surgical specialties took a lead role for autism.
- Staff told us that they did not have access to an inpatient disabilities nurse specialist. All patient referrals went to the registrar or consultant.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. These included information on how to contact the customer care team, which included the Patient Advice and Liaison Service (PALS).
- The patients we spoke with were aware of the process for raising their concerns with the hospital.
- We saw that noticeboards included information such as the number of complaints and compliments received during the current month. The staff we spoke with understood the process for receiving and handling complaints.
- Formal complaints were recorded on the hospital's incident-reporting system and managed by the customer care team. The ward and theatre managers were responsible for investigating complaints within their areas.
- Hospital data showed that there had been 42 complaints across the surgical services between October 2013 and September 2014. The hospital had a target to investigate and respond to all complaints within 28 days. The complaints information we looked at showed that all complaints had been investigated but complaints were not always responded to within 28 days.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.

Are surgery services well-led?

Requires improvement

There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks. However, we found that, when issues were identified, timely action was not always taken to address those risks: for example, the replacement of theatre tables, redecoration and maintenance of the day case theatre and maintenance of the shower room on the day case ward.

The theatres department had not had a theatre manager since December 2013. The theatres were managed by two theatre leads who were band 7 nurses. The theatre leads reported to the head of service for surgical specialties and were responsible for the day-to-day management of the theatres department. There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available across the surgical services.

There was routine public and staff engagement and actions were taken to improve the services. The staff we spoke with told us that they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The management team understood the key risks and challenges to the service and how to resolve these.

Vision and strategy for this service

- The surgical specialties had a clear vision and strategy with clear aims and objectives.
- The trust's quality strategy for 2012–15 included performance targets relating to patient experience, effectiveness of services and patient safety. The surgical services line objectives for 2014/15 were based on the quality strategy and included specific performance targets across the surgical services.
- The trust vision and values were visibly displayed across the wards and theatre areas we inspected and staff had a good understanding of the vision and values.

Governance, risk management and quality measurement

- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks. However, we found that, when issues were identified, timely action was not always taken to address those risks: for example, the replacement of theatre tables, redecoration and maintenance of the day case theatre and maintenance of the shower room on the day case ward.

- During the inspection, we looked at the risk register for surgery and saw that key risks had been identified and assessed. The risk register was maintained and reviewed at monthly surgical specialties SQS meetings.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through monthly performance dashboards.

Leadership of service

- The surgical services were divided into specific surgical specialties and each specialty had a clinical lead in place. The surgical specialties were consultant-led and medical staff spoke positively about the support they received.
- The surgical wards had clearly defined and visible leadership from ward managers who reported to the matron for surgical specialties. The ward-based staff we spoke with told us that they understood the reporting structures clearly and that they received good management support.
- The theatres department had not had a theatre manager since December 2013. The theatres were managed by two theatre leads who were band 7 nurses. The theatre leads reported to the head of service for surgical specialties and were responsible for the day-to-day management of the theatres department.
- The theatre staff we spoke with told us that they received good support from the theatre leads but they also told us that the head of service for surgical specialties was not always visible in the theatres department.

Culture within the service

- The staff we spoke with were passionate about the care they delivered, highly motivated and positive about their work.
- Hospital data for October 2014 showed that the staff turnover rate across the surgical wards and theatres was 14% and higher than the overall 2014/15 target of 13%. However, the data also showed that staff turnover had been consistently low between April 2014 and August 2014.
- Hospital data showed that staff sickness levels over the past 12 months across the surgical services were 4.8%, which was worse than the England average during that period.
- Staff sickness levels were reviewed daily and staffing levels were maintained through the use of bank and agency staff.

Public and staff engagement

- The theatre and ward-based staff we spoke with told us that they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of compliments and complaints was displayed on noticeboards in each of the wards we inspected.
- Patient feedback was also obtained through routine patient experience surveys across the surgical services. For example, hospital data for July 2014 to September 2014 showed that the majority of patients responded positively in relation to their involvement in care and treatment and with regard to whether staff treated them with dignity and respect across the surgical services. There was also ad hoc engagement with the public via patient support groups.
- The staff we spoke with told us that they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via 'learning into practice' newsletters and other general information displayed on noticeboards in staff rooms.
- The head of service for surgical specialties told us that the findings from the 2013 survey of NHS staff were reviewed as part of routine SQS meetings to look for improvements to the service.

Innovation, improvement and sustainability

- Clinical audit meeting minutes showed that medical staff carried out local audits in areas such as VTE assessment and medication prescribing to look for ways to improve staff practice and patient care.
- The use of rapid recovery care pathways had reduced the average length of stay for patients undergoing elective hip and knee surgery.

Surgery

- Ward staff spoke positively about the use of electronic handheld devices for monitoring patient observations. The trust also planned to introduce electronic patient records across all its services; however, this project was in its early stages at the time of our inspection.
- The matron, clinical director and head of service for surgical specialties told us that they had clear objectives and were confident the service was sustainable in the future. They identified that the key risks to the service were: the recruitment of suitable nursing and medical staff; financial challenges due to the size of the organisation; and the range of services that could be provided.

Critical care

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

Information about the service

The critical care unit (CCU) at Macclesfield District General Hospital (MDGH) had seven critical care beds where patients received monitoring and treatment for life-threatening conditions. The service had the staff and facilities to provide level three care to four critically ill patients and level two care to three patients who required either organ support or closer monitoring in the immediate post-operative period.

The unit provided care for people from 18 years of age upwards. Consultant cover was provided by a team of nine consultants with six of these being trained in intensive care. There was a critical care outreach service that was available on weekdays between 8am and 6pm.

Summary of findings

The introduction of the National Early Warning Score (NEWS), a system used to determine whether or not a patient's condition was deteriorating, had been effective and audits had shown a marked improvement in the recording and use of observations. However, the outreach service that provided support for the management of deteriorating patients on the wards was limited to weekdays only with no out-of-hours or weekend support provided. Consultant cover was limited due to only six of the nine consultants being trained in intensive care. Also, there was a reliance on locum cover for junior doctors' vacancies. Only 80% of patients were assessed by a consultant within 12 hours of admission to the CCU and the provision of two daily ward rounds was not achieved at weekends.

Care was delivered in the CCU by a well-led team of competent nursing staff and in accordance with national and best practice guidance, for example National Institute for Health and Care Excellence (NICE) guidance. The service was effective at monitoring, managing and improving patient outcomes. Patients and relatives spoke positively about the care they had received and the kindness and efficiency of the staff. Staff were responsive to patient feedback and used information to improve the quality of the service.

There were reliable and effective systems in place, including for reporting and learning from incidents. Infection prevention and control measures, including hand washing and the use of personal protective

equipment, were practised well and the unit was found to be clean and well maintained. There were reliable planned maintenance systems in place to ensure that equipment was available for use and fit for purpose.

Are critical care services safe?

Requires improvement

The medical staffing arrangements meant that there was a limited number of consultants with intensive care training and there was a dependence on locum doctors; on occasion, the latter were reported to lack the ability to care for critically ill patients. Added to this, the outreach service was available only on weekdays and there was no out-of-hours provision.

There were effective systems for reporting and learning from incidents. Staff understood their responsibilities to raise concerns and record incidents and near misses. We saw from the safety thermometer indicators that the unit had a low level of incidents in most categories. The unit was clean and equipment well maintained. Staff used good infection prevention and control measures to keep patients safe. Medicines were managed, administered and stored appropriately. Effective observation systems to alert staff about deteriorating patients had been introduced.

Incidents

- Staff understood how to use the hospital electronic incident-reporting system and were aware of their responsibility to raise concerns and report near misses and safety incidents. They reported that the system was easy to use and that they received feedback quickly about incidents reported. For example, one incident reported recently related to a patient's identity band, which had been found to include an incorrect date of birth. Once reported, the staff member received feedback to advise of the action taken to minimise the risk of recurrence.
- Actions and lessons learned from incidents were shared through staff meetings. An example of a recent incident was a chest drain that was not being managed safely. As a consequence, a training pack had been developed for staff caring for patients with chest drains.
- Information was displayed on staff noticeboards on, for example, the top ten areas of concern regarding incidents relative to critical care. This included information about how to minimise the risk of their recurrence.
- To minimise the level of pressure ulcer incidents, a specific set of skin care documentation had been

introduced to guide staff and help them appropriately assess patients at risk of developing pressure ulcers and the actions required to minimise the risk. We saw evidence of this being used appropriately.
- Trust board minutes for March 2014 showed that a review had taken place of the mortality review process. The medical director was leading on this for the trust and mortality had been made a standard item on the trust board's agenda. Due to the recent introduction of the change, we were unable to see evidence of any impact the revision to the process had made at this stage.
- A standard mortality form was used to collate and evaluate information to inform mortality and morbidity reviews.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm-free care'. Information was displayed for staff and visitors. This included information on, for example, falls and pressure ulcers. There had been one fall in the preceding 12 months and five incidents of pressure ulcers.
- Actions had been taken to minimise the risk of pressure ulcers through the introduction and use of a set of risk assessment and care-planning tools for skin care.

Cleanliness, infection control and hygiene

- The CCU was visibly clean and odour-free.
- Cleaning of the unit was carried out by permanent members of staff specifically allocated to the CCU; they clearly took pride in and care with their work.
- Staff had received training about infection prevention and control at induction and during annual mandatory training.
- There was a specific cleaning schedule in place. Staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor and we saw evidence that regular checks had been completed.
- Disposable curtains were used and dates for changing them had been placed on them.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included being 'bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves. We did not observe any procedures where eyewear was used; however, it was available.
- Hand-washing facilities and hand wash gels were readily available for patients, staff and visitors in all areas and were being used consistently.
- Staff explained that monthly audits of compliance with hand-washing criteria were completed, although we did not see the audit data during our inspection.
- We observed that sharps such as dirty needles were disposed of safely in bins provided for this purpose. The bins were not overfilled.
- There were information leaflets displayed in relatives' rooms about how they could help prevent and control infection when visiting the CCU.

Environment and equipment

- There were effective systems to ensure that equipment was maintained and fit for purpose.
- The engineers employed by the trust held detailed records of each piece of equipment, its history (such as the purchase date), frequency of repairs, and dates of planned maintenance due.
- We saw evidence that the engineers had a system that prioritised requests for repairs; for example, ventilators, defibrillators and beds were classed as 'priority one', which meant that they were attended to within one to 24 hours of a request being made.
- The resuscitation trolley was placed centrally within the CCU for quick access. It was maintained correctly through the practice of completing and recording daily checks to ensure that all the necessary equipment was in place and in working order.

Medicines

- Medicines were managed safely. The controlled drugs were stored in a locked unit and the keys held by the nurse in charge at all times. The other medicines were in locked cupboards.
- Medicines requiring refrigerated storage were stored appropriately. We saw that the temperature of the refrigerator was checked each day. Staff were aware of what action to take if the fridge temperature was outside safe parameters.

- Medicines were recorded and administered accurately. We observed the preparation and administration of intravenous, oral and controlled drugs. All medicines were administered safely and correctly in accordance with the hospital's policy.
- Records showed that there had been few medication incidents, but as a result of the incidents that had occurred, the hospital had developed an electronic training package for staff to use.
- Entries in the controlled drug register were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for, and any destruction of medicines was recorded.

Records

- We reviewed records for two of the four patients using the service at the time of the inspection.
- Records were completed and stored in accordance with trust policies.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for falls, pressure ulcers and nutrition screening.
- Records were designed in a way that allowed essential information, for example on allergies and medical history, to be documented and viewed. The records contained treatment details and care plans.
- There was evidence in the care plans of discussions with the patient and their relatives where applicable.
- Vital signs were well documented along with cardiac and respiratory indicators.
- Prescription drug charts were clear and complete. Medicines were signed for appropriately; if medicines were discontinued, the charts were signed and dated on the date of discontinuation and crossed through.

Safeguarding

- Staff had been trained to recognise and respond to any safeguarding concerns in order to protect vulnerable patients.
- Records showed that all staff had received training about safeguarding adults.
- There was clear information displayed for staff about who to contact and how to escalate and report a concern.
- We spoke with three staff regarding their role in ensuring that patients were safeguarded from abuse. All staff were clear about their responsibilities to report abuse, as well as about how to escalate concerns both internally and externally.

Mandatory training

- We saw from hospital records that the majority of training for staff in mandatory subjects was up to date.
- In the CCU, over 95% of all mandatory training had been completed.
- Staff said that they were personally responsible for ensuring that they completed their training; much of it was via e-learning, which was checked and reviewed by the matron or their manager.

Assessing and responding to patient risk

- NEWS had been implemented to inform and support clinical judgements and decisions regarding treatment. NEWS is a mechanism for calculating certain indicators that show whether or not a patient's condition is deteriorating and whether further intervention is required. A high score triggers intervention from a senior nurse or doctor to ensure that any changes in the patient status are responded to immediately.
- There was an outreach team that provided support for the management of deteriorating patients on the wards. This service was available five days a week from 8am to 6pm. This was not in line with the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommendation from 2011 that outreach teams in hospitals should be available 24 hours a day, seven days a week.
- Staff we spoke with were complimentary about the service that was offered by the outreach team, particularly as they visited the wards to assess and offer advice to the staff on any patient that may be causing concern. The outreach staff told us that they had a good relationship with the CCU consultants and were able to approach them for advice, should they need to.
- Only 80% of patients were reviewed by a consultant within 12 hours of admission to the unit, which could mean that those not assessed within the recommended timeframe may not be prescribed or receive timely treatment; there would therefore be a potential risk of

harm. This was identified through a monthly critical care audit of five patients a month. As a consequence, the head consultant had ensured this this requirement was included in doctors' job plans
- The recommended standard of completing two ward rounds daily was not always achieved, particularly at weekends when medical cover was limited.
- All staff had attended an annual course on the care of acutely ill patients to ensure that they remained up to date and could appropriately meet patients' needs in the CCU.

Nursing staffing

- The unit followed the core standards of the Intensive Care Society and the British Association of Critical Care Nurses for the staffing of CCUs. There was one nurse for each patient needing intensive care (level three) and one nurse for every two patients needing high dependency care (level two). In addition, the nurse in charge was supernumerary, except occasionally at night time when this standard was not always achieved. We looked at recent staffing rotas and saw that this situation arose no more than once a month.
- On the day of our inspection there was a nurse for each patient. The staffing rota was planned and staff worked on a rotational basis on days and nights. The nurse manager informed us that staff shortfalls were covered mostly by the CCU's own staff or by internal bank staff.
- At the time of our inspection, there were two nurse vacancies; however, the ward manager told us that one post was being recruited to and the other had already been provisionally filled.
- Data provided by the human resources team showed that there was minimal use of agency or temporary staff within the CCU.
- The manager of the unit explained that agency staff, when booked, were provided by an agency that was known to them and that had provided evidence that the staff they supplied were qualified and had current registration with the Nursing and Midwifery Council. In addition, agency staff who had not previously worked on the unit were given a brief induction that included how to respond to emergencies and how to use equipment correctly.
- There was a good handover between nursing staff when shifts changed. A formal handover to the nurse coming on duty took place at the start of each new shift in the patient's bed space.
- There was a ward clerk in post from Monday to Friday who was able to free up the nurse in charge from non-clinical duties.
- There was a balanced mix of senior and more junior members of staff.

Medical staffing

- Care in the CCU was led and delivered by consultants. There was a total of nine consultants who worked in rotation and were responsible for providing senior cover for the CCU and the maternity unit. Only six of the nine consultants were trained in intensive care; the head of department recognised that this was not ideal. They said that this sometimes resulted in possibly inappropriate admissions to the unit.
- In addition, there were 16 junior doctors' positions but only 10 were in post at the time of the inspection. They provided care to the patients under the jurisdiction of the consultant. Due to the vacancies, some of these positions were covered by locums; it was reported that they were of varying ability.
- Guidance from the Intensive Care Society and the British Association of Critical Care Nurses states that consultant work patterns should deliver continuity of care. The consultant head of department told us that consultant cover over three consecutive days was currently being trialled to improve continuity of care.
- At night and at weekends, not all the consultants were intensivists (doctors specialising in critical care medicine). The hospital had consultants on call out of hours, plus a tier of junior doctors to provide secondary on-call cover. The core standards of the Intensive Care Society state that consultants on call for intensive care units (ICUs) must not be responsible for providing other services, such as covering maternity services, in addition to their commitment to the ICU.
- At weekends, there was only one intensive care consultant responsible for providing senior cover. This meant that only one consultant-led ward round was held daily on the unit, rather than the two recommended in the core standards of the Intensive Care Society and the British Association of Critical Care Nurses.
- The consultant head of department told us that the standard of handovers between doctors had previously been poor, a situation that had been identified via the

monthly audit of notes. We saw that a new template had been introduced to use during rounds and handovers. They said that this had only recently been introduced and its effectiveness had yet to be audited.

Major incident awareness and training

- There were escalation plans in place to allow the early identification of pressures and associated clinical risks at unit level and to enable proactive management of identified risks at unit and department level. The hospital had contingency plans to respond to emergency situations including a loss of essential services such as electricity, telephone or IT functions.

Are critical care services effective?

Good

We found that care was delivered in accordance with national and best practice guidance, for example NICE guidance. The service was effective at monitoring, managing and improving patient outcomes. The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) data. This enabled the unit to be benchmarked on important clinical indicators against other comparable units. The service compared well with other units in terms of outcomes.

Nursing and medical staff were appraised to review their performance and to identify any further professional development required. Nursing staff were appropriately qualified and the proportion of those with the critical care nursing qualification (75%) was greater than the national average of 50%. A training needs analysis had been completed and findings had been effectively responded to, for example by introducing new training sessions. The use of NEWS had been implemented. An outreach service was provided but only on weekdays between 8am and 6pm. Pain relief and nutrition were well managed.

Evidence-based care and treatment

- All patients in the CCU were assessed by the outreach team prior to discharge and followed up after discharge.
- The outreach service was compliant with NICE guideline 83 (Rehabilitation after critical illness).
- Staff explained that the use of NEWS had been introduced along with the use of an electronic observation recording system to all acute wards in accordance with NICE guideline 50. Compliance with the recording of patient observations had subsequently been audited and risen from 72% to 98%. A set of competencies had also recently been developed to assist staff in using recorded observations in order to recognise and respond to episodes of acute illness in a timely and effective manner.
- Since the introduction of the skin care documentation, local audits had been undertaken to measure their effectiveness in identifying the risk of pressure ulcers and in preventing them.

Pain relief

- Records showed that patients were frequently assessed using pain score tools to help patients indicate the level of pain they were experiencing, if any.
- Staff had good access to a pain nurse specialist when required.
- Staff had received appropriate training in the use of medical devices to assist with pain control, such as syringe drivers. This ensured that they were used safely and effectively.

Nutrition and hydration

- The unit used the malnutrition universal screening tool (MUST) to assess the nutritional needs of patients.
- Patients told us that they thought the quality of food was good.
- We noted that scores for satisfaction with the quality of food had consistently been high in the patient-led assessment of the care environment (PLACE).
- Consultants and staff reported that there was a timely and effective response to requests for a dietician when required.
- East Cheshire NHS Trust had participated in an audit of compliance with NICE guidance CG32 (Nutrition support in adults) and was found to be compliant with six of the 10 criteria and partially compliant with the remaining four: for example, all areas were found to be using MUST appropriately.

Patient outcomes

- Staff had carried out a number of mandatory local, regional and national audits to monitor the effectiveness of the service. They participated in and

contributed data to ICNARC. ICNARC collects data from participating CCUs, such as average occupancy, death rates and readmission of patients to the unit within 48 hours of transfer out.
- The CCU performed in line with the comparator for four of the ICNARC indicators. One of these indicators was that discharges were not delayed; this meant that beds in the unit were not blocked by patients no longer requiring the service.
- The percentage of deaths occurring in hospital was at a similar rate to the England average.
- A critical care audit of five patients a month was completed. This had revealed shortfalls in care; appropriate documentation, such as improved systems of handover, had been developed to resolve this.

Competent staff

- Staff had good access to training, including on advanced life support. One staff member had recently completed a critical care course supported by the trust.
- New staff received regular support and a review of their progress from the senior nurse and clinical educator. They worked for their first six weeks on a supernumerary basis under supervision before working independently to ensure that they were familiar with their duties and the equipment used.
- The unit had 75% of nurses with a formal critical care qualification, including the lead nurse; this was higher than the required proportion of 50%. Best practice guidance from the Intensive Care Society and the British Association of Critical Care Nurses states that the lead nurse for CCUs should have a critical care qualification.
- There was a good system in place for monitoring compliance with training required to use medical devices safely.
- A training needs analysis had been completed. We saw evidence of how the findings of the analysis had been used: for example, short training sessions had been provided on topics such as septicaemia and wound management.
- All band 5 staff had completed intermediate life support training and all band 6 and 7 staff had completed advanced life support training.
- Where performance issues had been identified, these had been managed well through discussion, the setting of objectives and the provision of further training.
- Staff received regular appraisals and supervision when required.
- There were three trainee doctors at any one time, with the more junior of these supervised. New doctors also attended the hospital induction programme when commencing work at the hospital.
- We reviewed trust-wide data and saw that appraisals had been completed for 94% of medical staff within the trust.

Multidisciplinary working

- Nursing staff told us that they felt supported by the medical team and were impressed by the way in which consultants took time to explain medical conditions and new procedures to them. They said: “You would never get a consultant explaining so much on a ward.”
- Consultants told us that the service had good access to – and systems in place to safely transfer patients to – specialist centres such as cardiac, vascular and neurological units when required. We saw that there were local transfer guidelines to support staff managing the safe transfer of patients.
- The service had monthly critical care operational meetings; staff said that they found these useful as they enabled them to identify issues and develop solutions, such as improving communication and handover sessions.
- There was a critical care outreach team; however, this was currently only available on weekdays between the hours of 8am and 6pm. To minimise the risk of a lack of outreach services out of hours and to ensure effective handover, the outreach team completed a CCU handover document that it provided to the senior night nurses. This contained essential patient information such as their vital observations and NEWS. The same information was provided by the night team to the outreach team the following morning.

Seven-day services

- Staff reported that the consultant on call was easy to access out of hours and felt they were mostly able to obtain the necessary medical advice required.
- Radiography services were mostly available seven days a week. The exception was magnetic resonance imaging (MRI), which required a transfer to another hospital based in the West Midlands, but the senior nurse told us that this seldom occurred.
- There were two daily ward rounds to review patients’ needs, except at weekends when there was only one round completed.

Critical care

Access to information

- There was a range of information for families and friends displayed in reception areas and in relatives' rooms on such topics as brain stem death, blood transfusion and organ donation.
- Staff had access to useful information on the hospital intranet, including contact details to access specialist services not provided by the hospital, such as neurological and liver services. Other information available included a renal calculator to assist with the planning of dialysis treatments.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Within the trust policy there was clear, step-by-step guidance specific to patients being cared for in critical care regarding the appropriate use of restraint for patients who were confused.
- The senior nurse for critical care told us that they seldom needed to apply restraint but could recall the last occasion when this had been required. They were able to describe the steps taken, including discussion with the family about the need for restraint in accordance with the hospital's policy.

Are critical care services caring?

Good

Comments from patients and relatives about the care they had received were very positive. Patients were cared for by knowledgeable and caring nursing staff who felt valued by their manager and the consultants they worked with. Patients were treated with dignity and their privacy was protected when personal care was provided.

Patients and their relatives were involved in decisions about care and given support and information by staff to help them make informed choices. Care plans were personalised and risk assessments were used effectively and up to date. We observed emotional support being provided to relatives by staff in a kind and empathetic manner.

Compassionate care

- Patients told us that they felt that their privacy and dignity were maintained. Staff ensured that they used screens to protect patients' dignity and spoke quietly when discussing and planning their care with them. They told us communication was good and they always understood despite many staff providing their care and explaining things to them.
- There was a relatives' room with a supply of refreshments and information. There was also a separate room where staff could hold private one-to-one discussions with relatives when required.
- Relatives said: "It's a lovely place; I wouldn't mind being a patient in here." Another relative said: "All the staff do a wonderful job."
- One former patient visited the unit during our inspection to thank the staff for their care.
- Recent patient survey results showed a good level of satisfaction with the care provided. The results also showed that patients and relatives felt they had been kept fully informed and that staff had listened to and answered their questions.
- Relatives had written cards of appreciation about the care provided. One person had written: "My father is living proof these people work miracles every day." Another person had written: "The nurses and doctors were open and honest; they were realistic and helped keep us strong and hopeful."
- Staff were discreet when speaking to people at the nurses' station or on the telephone to ensure confidentiality.

Understanding and involvement of patients and those close to them

- Relatives told us that they were provided with information and staff supported them during their first visit to the CCU to help prepare them and to help them understand what to expect. They found this helpful.
- Families received contact information so that they could enquire after their relative whenever they needed to.
- We observed that staff took time to explain care to patients before providing it, such as giving medication or repositioning a patient to make them comfortable.
- Care plans in the two records we looked at were personalised and up to date. Observation and nursing care records were kept at the bedside but medical records were kept securely at the duty station to ensure confidentiality.

Emotional support

Critical care

- We observed that visitors to the unit were greeted in a warm and friendly manner.
- Visitors received an explanation about what to expect when they visited the unit to see their relative for the first time to help them prepare and adjust to the surroundings.
- Some patients had difficulties recalling their time in critical care, which some found upsetting. To address this, the use of patient diaries had been introduced to help patients understand their experience once discharged. The diaries were used by staff and relatives to record progress, visits from relatives and any significant events.

Are critical care services responsive?

Good

There were resources to meet the needs of people who may not have English as their first language. A chaplaincy team was available to meet people's spiritual needs. Safety goals and risk assessments were documented, acted upon and evaluated. Feedback from patients and relatives was encouraged and this information had been used to improve the service.

MDGH CCU was not able to meet some specialist clinical needs, such as ongoing care for brain-injured patients, but there were effective systems in place to respond and to provide safe transfer to specialist centres when required. There had been eight occasions in the past year when a bed had not been immediately available but the needs of the patients had been responded to appropriately.

Service planning and delivery to meet the needs of local people

- MDGH CCU was not able to meet some clinical needs, such as ongoing care for brain-injured patients, but there were effective systems in place to respond and to provide safe transfer to specialist centres when required.
- The unit took acute medical patients directly from accident and emergency and received elective surgical patients who required close monitoring post-operatively.
- There were procedures to manage patients safely when a bed was not immediately available in the CCU. Patients were treated in recovery where an anaesthetist and essential equipment such as a ventilator could be accessed easily.

Meeting people's individual needs

- There was an interpreter telephone service available if required. Staff told us that some doctors and nurses on the unit who were bilingual were also used if they spoke a patient's particular language.
- Written information was supplied in multiple languages and was available from the customer care department. Literature we saw explained the different formats and languages in which information was available and how this could be accessed.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for moving and handling and pain assessments.
- A chaplaincy team was based at the hospital to provide support for patients' spiritual and religious needs.

Access and flow

- In the preceding 12 months, there had been eight occasions on which a bed had not been immediately available in the CCU because adult bed occupancy had reached 100%. On these occasions, patients were admitted from the ward to recovery, where such procedures as the insertion of central lines could be undertaken in a safe environment prior to admission to the unit.
- Data we saw showed that incidents of delayed discharges (more than four hours) or discharges to the ward out of hours were minimal and below the national average. However, nursing staff told us that achieving discharges within the four-hour timeframe was sometimes difficult to achieve.

Learning from complaints and concerns

- There had been a slight increase in written complaints within the overall trust but there had not been any complaints reported within the CCU at MDGH. Several environmental concerns about the CCU had been raised by patients attending outpatient clinics. They recalled hearing "bombs going off" and the "sound of engines" while they were in the unit. These issues had been

investigated and detected as the noise of metal bins closing and the noise emanating from the electric paper towel dispenser. The bins had since been replaced with plastic ones and the towel dispenser had been changed.
- Patients had reported feeling disoriented; to reduce this concern, clocks displaying the date and time had been displayed prominently in the unit for patients to see.

Are critical care services well-led?

Good

The critical care team was well motivated and supported at local level. The local nursing leadership was respected because of its clinical skills and knowledge. There was effective communication from the head of nursing to ensure that senior nurses within the hospital were kept informed of developments. There was also shared learning.

Managers were aware of the shortfalls in the service and were taking measures to address these, such as providing advanced critical care practitioners and a seven-day outreach service. However, these plans had not been approved at the time of the inspection. Audit and outcome data was used effectively to improve the quality of care.

Vision and strategy for this service

- Staff were aware of the trust's vision and values.
- The current chair of the Cheshire and Merseyside network outreach group was the critical care nurse consultant, who also led the local outreach team. We saw evidence that they were developing competencies for use across the network to enable standardisation and consistency of training for staff to facilitate the delivery of effective care.
- The development of the advanced critical care practitioner role was being explored by the consultants as a way of addressing the shortfall in the availability of middle-grade doctors. Consultants explained that they anticipated their training would be provided within the critical care network, but this was a long-term plan.

Governance, risk management and quality measurement

- The service leads met on a monthly basis to review service provision and to identify and address shortfalls in the quality of the service, such as breaches of targets relating to admission to and discharge from critical care.
- Audits were carried out and action that arose from the audits was completed. This included the correct use of the NEWS observation tool, which had been implemented to inform and support clinical judgements and decisions regarding treatment.
- Staff were aware of the key performance outcomes and received feedback from incidents to help continuously improve the service.

Leadership of service

- Staff received a trust team briefing from the trust board about events, changes and future plans for the hospital. Staff reported that some information was helpful, but the financial information was difficult to understand.
- Weekly 'keeping in touch' meetings had been introduced for senior nurses (band 7). This was attended by the director of nursing and provided a forum to review key information including compliance with infection and prevention standards, the provision of formal training to access the risk register, and other safety matters such as the management and quality-checking of mattresses. Staff told us that they felt these meetings helped raise awareness across the organisation and helped them learn from incidents.

Culture within the service

- Most staff we spoke with were very positive about working in the hospital. They felt valued and well supported. They told us that they were made very welcome when starting as a new member of staff. They said: "The nurse in charge is always there to provide support and guidance"; "There is a positive morale. Everyone enjoys what they do" and "We always know who to go to for help."
- A survey completed by the General Medical Council regarding the National Training Scheme showed that doctors' training needs were met within expectations. For example, doctors felt that they received adequate clinical supervision, induction and local teaching.
- Staff were aware of the trust's whistleblowing policy and knew how to raise a concern. Staff told us that they had not needed to do so but said they felt they would be supported if they needed to discuss a concern with their manager.

- Staff felt supported by their manager and there was good communication between senior management and staff within the CCU. Overall, staff felt that the unit was a good place to work. This feedback was further supported by the results of the NHS staff survey.

Public and staff engagement

- We saw that there had been fundraising activities to help improve facilities for relatives of patients in critical care.
- The service had a feedback form displayed that was specific to the critical care service. This included questions about satisfaction with privacy and dignity, being kept informed about the patient's condition and the helpfulness of staff. Although return rates of completed forms were low, feedback was very positive.
- In the recent staff survey, the majority of staff had reported that they felt valued and had good support from their manager.

Innovation, improvement and sustainability

- An 'Aware' course had been developed for use by healthcare assistants to help improve their understanding of observations and how to recognise a deteriorating patient.
- At the time of the inspection, the outreach service was available only from Monday to Friday between the hours of 8am and 6pm. A business case had recently been prepared and submitted to the trust executives to extend the outreach service to provide a seven-day, 24-hour service to ensure compliance with NICE guideline 50.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services for East Cheshire NHS Trust were based at Macclesfield District General Hospital (MDGH). They served the population of Macclesfield, Congleton, Knutsford and the surrounding areas. The services included antenatal and postnatal care (inpatient and outpatient), a delivery suite, ultrasound scanning, an early pregnancy unit, a gynaecology outpatient clinic and an inpatient service. A team midwifery approach meant that community services were provided by midwives who rotated between working in the community and in the hospital. They provided antenatal care, home birth and postnatal care.

The service was managed through the East Cheshire NHS Trust women's and children's business unit and was led by a clinical director and a head of midwifery. There were 1,823 births at the trust from April 2013 to April 2014. In the past three months, the number of births had decreased (by 34 births) to its lowest number when compared with the previous two years.

Summary of findings

There had been an emphasis on completing the necessary audits and training to obtain and maintain level three in the Clinical Negligence Scheme for Trusts (CNST). This recognises a high standard of training and care. However, the standard of some of the more basic day-to-day practices and procedures, which were not included in this work, had not been maintained. Staff did not always follow procedures correctly for the management of controlled drugs or for the completion of some records. There was no formal system for deciding the serious nature, or potential outcomes, of an incident or for how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared. Some of the facilities, such as those for parents of babies in the neonatal unit and to facilitate infant feeding, were not fit for purpose.

There were no inpatient beds used specifically for patients undergoing a gynaecology operation or termination of pregnancy. Such patients could be accommodated in a mixed ward but this did not protect their dignity or the potentially sensitive nature of the support they would need. A high number of gynaecology operations were cancelled at short notice. There was no clear vision or strategy to improve or develop gynaecology services within the hospital. The trust provided information regarding the strategy for gynaecology services but staff within the service were unaware of both the strategy and any of the

Maternity and gynaecology

development plans in place. There was a lack of monitoring of day-to-day procedures and this had led to poor practice not being identified or rectified. Not all areas of risk had appropriate assessments in place or actions to reduce those risks. The trust had identified the need to plan to sustain maternity services and had identified several actions. However, senior midwifery staff did not identify these plans when we spoke with them.

The maternity services used local and national data and good practice guidance to develop policies and procedures. The working procedures and outcomes were audited to monitor the effectiveness of the service. Action plans were in place to improve outcomes in the areas identified as being below either national standards or the trust's own targets, including for the number of normal deliveries and third and fourth degree tears. There was a multidisciplinary approach to the care and support of patients, with the inclusion of specialists from other medical areas such as diabetes management and mental health services. However, there was a lack of joint working with theatre staff. The competence of staff was monitored and midwives received the necessary supervision and support. Staff were caring and treated people with respect and dignity. People spoke highly of the care they had received and the attitude of staff. There were opportunities for staff to develop personally and professionally, with clear lines of leadership and accountability in the service.

Are maternity and gynaecology services safe?

Requires improvement

Some improvements in the service are necessary to ensure services are safe. There had been an emphasis on completing the necessary audits and training to obtain and maintain level three in the CNST. This recognises a high standard of training and care; however the standard of some of the more basic day-to-day practices and procedures, which were not included in this work, had not been maintained. Staff did not always follow procedures correctly for the management of controlled drugs or for the completion of some records.

The maternity services were provided within a unit that contained the antenatal, labour and postnatal wards. The environment was showing signs of wear and could not be cleaned adequately, which led to infection control risks.The trust had recognised these areas required improvement as part of their capital improvement programme 2014/15. However, we raised these issues with the service during the inspection and no improvement programme was discussed.

There was limited space, leading to some unsafe storage. There was no formal system for deciding the serious nature, or potential outcomes, of an incident or for how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared.

There was an emphasis on practice development, with staff benefiting from a thorough programme of skills and drills training.

Incidents

- Midwives said that they found the incident-reporting system easy to use and accessible. They were confident that incidents were investigated appropriately and they received feedback following a report.
- Learning from incidents was shared with all staff via the monthly emailed newsletter and the communication folder kept in the maternity unit. We saw that procedures had changed following incidents, such as the recording of safeguarding concerns.

- The midwife with a lead role in the management of risk and governance told us that there was no protocol for decision making in terms of how incidents were investigated. This meant that incidents that could lead to a high risk of harm, such as a baby being transferred between units without identity or security apparatus, were managed without escalation. This resulted in there being no written records regarding the investigation or the actions required to reduce the risk of recurrence or sharing of learning.
- Mortality and morbidity within the maternity services was discussed as part of the monthly clinical governance committee meetings.

Safety thermometer

- A safety thermometer for maternity services had been developed in May 2014. This contained information regarding physical issues such as maternal infections and women's perception of safety, including their concerns about not being taken seriously. Midwives were aware of this information and any actions required from the outcomes were discussed at meetings and in the monthly newsletter.

Cleanliness, infection control and hygiene

- There had been no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) in the maternity unit since April 2014.
- A hand hygiene audit had been completed monthly, with an average of 97% scored in the past seven months. We saw staff wash their hands at appropriate times.
- A 'no touch' hand-washing station was at the entry to the ward and staff reminded visitors to wash their hands on entry to the unit.
- Personal protective equipment (PPE) was available throughout the unit. However, we noted that one dispenser for plastic aprons, which was situated in the main part of the ward, was empty on two days of the inspection.
- Some areas of the maternity unit had signs of wear and tear which meant they could not be cleaned. This included bare and worn wood around sinks and in the sluices. Chipped shelving in the clinical areas, offices and sluices and wooden doors and doorways with bare wood were present.The trust had recognised these areas required improvement as part of their capital improvement programme 2014/15. However, we raised these issues with the service during the inspection and no improvement programme was discussed.
- The portable medical gas cylinders were rusty, as were the trolleys on which they were stored. This meant that they could not be cleaned adequately in line with infection control guidance.

Environment and equipment

- There was a lack of storage facilities on the maternity unit. This led to some unsafe storage: for example, items stored in corridors and rooms that were open to women were full of equipment (including medical equipment).
- Doors were left open to rooms that contained medical equipment, such as used sharps receptacles and disposable medical instruments. Some did not have any means of securing the door, such as a digital keypad. We saw women accessing these areas unsupervised, despite a notice to the contrary being displayed.
- The door to the sluice, which was also where medical gases were stored, was propped open. This presented a fire risk.
- Staff told us that they had sufficient equipment to care safely for the patients. This included cardiotachygraphy machines.
- Emergency equipment, such as adult and baby resuscitation equipment, was stored on specific trolleys and was easily accessible. A daily check was recorded.
- There were maintenance stickers on the equipment that included a date. These did not specify whether that was the date when the next check was due, or the date the last check had been carried out. There was no log of equipment maintenance kept on the ward. In order for staff to be assured that they were using equipment that was fit for purpose, they would have to check the serial number with the medical engineering department. This meant there was no easy way for staff to know whether equipment was safe to use.
- There were two birthing pools available for women who were assessed as being at a low risk of complications in labour. Staff had received training in the emergency evacuation of women from the pools; however, there was only one emergency evacuation net available. This meant that there could be a delay in locating emergency equipment should it be required if both pools were in use.

Maternity and gynaecology

Medicines

- Medicine administration in all areas of the maternity unit was managed by the midwives; there were no facilities for women to administer their own medicines. This meant that women could not remain independent in medicine administration should they wish to do so.
- Medicines were stored appropriately in locked cupboards. Fridges were locked and records showed the temperatures were checked and recorded daily.
- Information provided by the trust showed that 65% of staff in the women's and children's services were up to date with clinical mandatory training. This training included medicines management. The trust confirmed that there was no assessment component to the medicines management training. This meant that there was no method of assessing the competence of staff to manage medicines safely.
- The policy for daily checks of the stock of controlled drugs was not followed in practice. During one check we found that one 10mg vial of morphine had an expiry date of September 2014. The trust's 'Safe and secure handling of controlled drugs' policy stated that ward or departmental managers were responsible for ensuring that "daily checks and expiry date checking is undertaken". This had been carried out incorrectly for the preceding two months, as the out-of-date stock should have been disposed of.
- This out-of-date vial was stored in an open box with other vials that were in date. The section containing the expiry date had been removed. This did not comply with the trust's 'Safe and secure handling of medicines' policy, which states: "Medicines must be stored in the containers in which they are supplied by the pharmacy department. They must not be transferred to another container." We brought this incident to the trust's attention and it took immediate action to address our concerns.

Records

- The patient care records we reviewed contained numerous documents including assessments and plans of care.
- Risk assessments, such as mental health assessments, were present in the documentation. Where these were continuous, not all had been completed by the medical staff when required.
- Medical records were stored securely on the wards.
- 'Red brick road' books for the baby's health records were in use and completed. This met the national standard of the Royal College of Paediatrics and Child Health of providing parents with a record of a child's health and development from birth.
- When a baby was transferred from the labour ward or postnatal unit to the neonatal unit, no written handover information was provided. This meant that until the nurse could access either the paper records (which did not always accompany the baby) or electronic records they were relying on verbal information.

Safeguarding

- The midwives and medical staff knew their responsibilities with regard to reporting any concerns they had for the safety of a patient. They said that clear procedures were in place for this.
- There was one midwife with the lead responsibility for safeguarding. They had developed systems to ensure that risks to vulnerable pregnant women and babies were identified at an early stage. This included the development of one record to identify those at risk; this was embedded in the electronic patient records. A highly visible hard copy was placed in the notes to ensure that all those involved in their care were aware of the risks.
- The midwife with lead responsibility for safeguarding had links with local adult and child safeguarding personnel in social services and shared information appropriately if necessary.
- The common assessment framework approach was in use and all midwives received training in this approach to safeguarding. This meant that all agencies, including the midwives, who may be involved in the support of a family or child had access to multidisciplinary assessments and support plans.
- There was a team midwife system, whereby the geographical area was divided into eight teams of two or three midwives to provide continuity of care. This meant that women and midwives built relationships; they said this helped them to recognise issues of safety for women and babies, such as a change in mood or circumstances, at an early stage.
- If a woman did not attend an antenatal appointment there was a procedure in place to ensure that they were contacted as soon as possible. This included clear escalation procedures should there be concerns.

- There was an electronic baby-tagging system in place. We saw that staff reacted quickly when it was activated.
- Data showed that 93% of staff in the women's and children's services division were up to date with core mandatory training, which included basic safeguarding. The data provided by the trust also showed that 85% of staff were up to date with safeguarding training to level three standard. Some 87% of midwives and medical staff had completed training in mental health that included risk assessment methods and referral routes.

Mandatory training

- Staff were reminded when their training was due. One midwife told us that their training had been delayed for three months due to staff shortages, but they were now up to date. This meant that staff could become out of date with their mandatory training.
- Midwives and medical staff on the maternity unit completed both the trust mandatory training and maternity mandatory and statutory training. Information provided by the trust showed that 93% of staff in the women's and children's services were up to date with core statutory and mandatory training; however, 35% were not up to date with mandatory clinical training, which included medicines management.
- As at November 2014, 86% of staff were up to date with the maternity-specific training, which included newborn life support and maternal resuscitation. Multidisciplinary skills and drills training was provided for procedures such as management of haemorrhage and cord prolapse. This was completed using a simulation mannequin and was recognised within the North West Maternity forums as excellent practice for midwives' professional development.
- The maternity care assistants who assisted in obstetric theatres during caesarean sections had completed a 20-week training course. They had obtained a level three qualification in perioperative support. 50% of the midwives had also completed this training to assist in theatre; however, they did not routinely carry out this job role and this meant that they were unable to maintain the appropriate level of skills and competence.

Assessing and responding to patient risk

- Antenatal screening included risk assessments to identify potential concerns, which, if required, resulted in additional monitoring. Staff told us that women who presented with risk factors, such as diabetes or an increased body mass index, would be seen by a consultant earlier in their pregnancy than usual.
- A number of risk assessments were used, including an Obstetric Early Warning Score chart, to identify mothers whose condition was deteriorating. A Neonatal Early Warning Score chart was in place for newborn babies.
- Midwives said that medical staff responded quickly if they required them in an emergency. We saw an example of this for a gynaecology patient.
- An intensive care unit was available on site if required. Five women had required transfer to this unit in the past eight months, which was within the trust's target. The circumstances for these transfers were reviewed to ensure that any lessons for future care were learned.
- A neonatal unit was part of the maternity unit. Eight cots were available and care was provided by appropriately trained staff.

Midwifery staffing

- Staff numbers were reviewed monthly to ensure that staffing remained adequate to cover holidays and sickness.
- The midwife-to-patient ratio averaged at one to 30. This was higher than the recommended number of one to 28. The total number of births had decreased recently, and therefore we were told that the numbers would be kept under review. A staffing acuity guideline was in place based on Birth-rate plus. However this did not allow for the assessment to be done daily. The staff numbers were assessed daily at local level and contingency plans were used if activity required it.
- There were two full-time midwife vacancies and recruitment was under way. We were told that there were no problems with recruiting new staff.
- There were between seven and five midwives on duty during the day, with one maternity care assistant on duty most days. Staff said that there were enough midwives to manage the workload. They discussed how they supported each other to ensure that all shifts were covered sufficiently.
- One-to-one midwife care was received by 98% of women during labour; this was within the targets set by the trust.
- The midwives, except for those leading an area such as postnatal, rotated between working on the wards and in

the community. They did this as a team approach and it meant that there was some flexibility, within those teams, to enable them to work on the wards at short notice.
- There were two midwives on call and we saw that they were called in at night if required, for example to assist with an emergency caesarean section.
- The shift handover provided detailed information regarding the current circumstances, care and support of each patient on the ward. It was carried out in a way that protected the confidentiality of information.

Medical staffing

- There were seven obstetrics and gynaecology consultants employed by the trust. They worked a 'hot week' system, which meant that one of them was on call for the week. They had no other clinical duties for that week and they were supported by a middle-grade doctor who was also on call. They said this worked well in terms of continuity of care for the patients, as their care was managed by the same doctor over a seven-day period.
- Trainee doctors said that they were well supported by the senior doctors and they were able to contact someone to discuss issues at all times.
- The medical handovers were held in each ward area, included all staff grades, and were used as an opportunity to discuss issues and cases in an educational way.

Major incident awareness and training

- The head of midwifery was aware of their expected involvement in a major incident. Other staff were not aware of any role they might have. No maternity staff had been involved in a major incident drill. This meant that staff were not aware of their role should a major incident occur.

Are maternity and gynaecology services effective?

Good

The maternity services used local and national data and good practice guidance to develop policies and procedures. The working procedures and outcomes were audited to monitor the effectiveness of the service. Action plans were in place to improve outcomes in the areas identified as being below either national standards or the trust's own targets. This included the number of normal deliveries and third and fourth degree tears.

There was a multidisciplinary approach to the care and support of patients, with the inclusion of specialists from other medical areas such as diabetes management and mental health services. However, there was a lack of joint working with theatre staff. The competence of staff was monitored and midwives received the necessary supervision and support.

Some of the facilities, such as those for parents of babies in the neonatal unit and to facilitate infant feeding, were not fit for purpose.

Evidence-based care and treatment

- Medical staff were aware of the guidelines relevant to their practice, such as National Institute for Health and Care Excellence (NICE) guidelines for antenatal care. Most policies and practices met these guidelines with the exception the policy related to jaundice. One element of this policy was not in line with NICE guidance. The service was aware of this; this was a consultant body decision following audit.
- Royal College of Obstetrics and Gynaecology guidance was used to inform practice such as the management of post-partum haemorrhage.
- There was evidence of multidisciplinary working with specialists in the local and wider community in order to develop policies and procedures. This included improving access to mental health services and to termination of pregnancy services that were not provided by the hospital.
- The outpatient hysteroscopy service had been developed to reduce the inpatient rate from approximately 70% to 30%. This met good practice standards in reducing unnecessary inpatient stays.
- A large number of audits of the maternity services had been completed as part of the CNST monitoring process. These included clinical care, such as eclampsia management, and quality standards such as maternity triage. An audit meeting took place monthly with midwives and doctors of various grades. Any outstanding issues and results of audits were discussed at the monthly governance meetings. If required, action plans would be developed and monitored at the monthly meetings.

- A midwife was part of the regional group developing guidelines for avoiding stillbirth. Going forward they would be responsible for developing practice within the unit.

Pain relief

- Various methods of pain relief were available for patients including Entonox, injectable analgesia and epidurals. These were discussed with women prior to labour.
- A non-medical method of pain relief was offered in the form of hypnotherapy delivered by qualified midwives.

Facilities

- There were two birthing pools on the labour ward. The rooms for these had been refurbished recently, including the addition of en-suite shower facilities.
- There was no dedicated area for the storage of breast milk or for the preparation of infant feeds. The fridge for breast milk was located in a clinical room with disposable medical equipment present; this did not follow infection control guidance. Parents had to bring in ready-mixed infant feeds if they chose not to breastfeed.
- The area intended for parents whose babies were in the neonatal unit was stark, with no homely items for their comfort. The bathroom area was used as storage for staff and babies' equipment. This meant that parents had to use the communal facilities on the ward.
- The antenatal clinic was designed to ensure that women attending the early pregnancy unit had separate facilities to other patients, including a quiet room for discussing bad news and a separate waiting area.
- There was a bedroom with en-suite facilities on the maternity unit; this was away from other areas and had been designated as the bereavement room. This provided a space away from the labour ward and postnatal ward for bereaved parents to spend time with their baby should they wish.

Nutrition and hydration

- The rate of initiation of breastfeeding for new mothers was an average of 80% in the past seven months. This was slightly below the trust's own target but above the national target.
- Women were actively given advice and support by the midwives to breastfeed if they wished.
- The unit had achieved Baby Friendly status level three. This is a recognised United Nations International Children's Emergency Fund UK initiative and consists of three stages of assessment, including parents' feedback with regard to support for breastfeeding.
- There were plans to develop a specific tongue tie clinic as currently this was not a service offered at the hospital.

Patient outcomes

- In the past three months, the number of births had decreased (by 34 births) to its lowest number when compared with the previous two years. No reason for this had been identified.
- The rate of normal deliveries was lower than the England average. Over the past seven months, the average in the trust had been 34%, which was below its own target of 39%. The reasons for this were discussed as part of the clinical governance meetings and actions to improve the outcomes were in place.
- Elective caesarean sections had accounted for 13% of total deliveries in the past seven months. This was higher than the trust's target of less than 11%. Medical staff and midwives were aware of this high rate, and education, advice and support were provided in antenatal care and post-delivery.
- The issue of the high rate of elective caesarean sections was discussed at the clinical governance committee meeting in October 2014. The result was that a steering group was set up, led by a midwife, to investigate the reasons for it and to propose actions to reduce the numbers.
- There was no specific clinic for advising or supporting patients on vaginal birth after caesarean (VBAC). The rate for this was 45%, which was below the trust's target of 50%. We were told that a self-referral clinic consisting of three one hour slots was held each week as part of the supervisor of midwives clinic. However, it was recognised that there was no specific VBAC clinic. This clinic may be developed following the steering group findings.
- The number of deliveries resulting in a third or fourth degree tear (2%) was higher than the trust target. Medical staff told us there was to be an emphasis on skills and drills training for this and an audit was

underway to better understand the reasons for the high number. In addition all women returned to the consultant clinic for review and assessment in line with trust policy.
- The number of home births was low at 17 in the past seven months, compared with the trust's target of 45 per year. There was a strategy in place to improve home birth rates. However, staff did not refer to this strategy when we spoke with them.
- The numbers of maternal admissions to the intensive care unit and of babies to the neonatal unit were within the expected range.
- The maternity services had been commended by the North of England Local Supervising Authority for developing a weekly supervision clinic. This was led by the supervisors of midwives and a consultant and consisted of a one-hour appointment to discuss any aspect of maternity care the patient wished. This had been shared as good practice on a national level.

Competent staff

- Midwives said that they received annual appraisals, which included planning for their continued development, and 98% of midwives were up to date with their appraisals.
- The ratio of supervisors to midwives was one to 14. This met with the recommendation of one to 15.
- Midwives spoke highly of their supervisors and their availability. They said that they were able to discuss any issues they had with them and received timely, appropriate advice and support.
- The midwife team was considered to be a regional champion for fail-safe arrangements in the 2012 audit report for antenatal and newborn screening. This showed that best practice was achieved in the newborn bloodspot screening of babies, which is carried out for the early identification of diseases such as cystic fibrosis. The team told us that they had continued to maintain this high standard of newborn blood spot screening.
- However, data provided by the trust showed that newborn screening was below the expected standard in three of the five areas (not newborn bloodspot screening) in 2012. These areas had been continually monitored and practice had changed as a result. In a recent audit, carried out by the trust, it had achieved 100% of babies having their temperature taken within an hour of birth; we saw this to be the case during the inspection. Actions had been taken to ensure that an ophthalmologist carried out retinopathy screening prior to discharge and that babies remained in the neonatal unit until this was done.
- If the investigation into an incident showed issues of poor practice by a midwife, they received additional supervision, training and support to ensure that their competence was improved and maintained.

Multidisciplinary working

- Midwives and doctors of all grades said that there was excellent team working within the maternity unit. They discussed how all levels and grades of staff challenged each other to ensure that good practice was achieved. This included multidisciplinary presence at clinical governance meetings, audit meetings and debrief sessions following root-cause analysis investigations into incidents.
- There was no separate community midwife team as staff rotated between the hospital unit and the community. This led to an increased amount of face-to-face communication with women. Diaries were used to record telephone communications from patients and community staff rang in daily to check for any messages.
- There were some links with staff from other specialties, such as diabetes and endocrinology, and joint clinics were held.
- One midwife was working with regional colleagues from other trusts to develop a care pathway for morbidly obese patients.
- Midwives reported good links with local GPs and that continuity of care was provided by the team midwife approach, which assisted communication in the community.
- There was a lack of joint working with the staff in the operating theatres. This was mainly due to there being a specific dedicated obstetric theatre that was managed separately to the rest of the theatre suite. The maternity care assistants worked with the obstetric consultants in this theatre, which meant that there was no joint working with other theatre staff, except in an emergency situation. This had led to a lack of cohesion and cooperation between the maternity unit and theatre staff at a management level in areas such as staff training and development.

Seven-day services

- A consultant was on call for a week at a time, with a middle-grade doctor working with them. They were either in the hospital or available by telephone. Doctors and midwives said that they had never had a delay in response from the consultant on call.
- There was no seven-day sonography service in the antenatal clinic. There were two midwives completing their sonography training and there were plans to develop the out-of-hours service once this was completed.
- There was pharmacy and pathology support outside normal working hours.

Access to information

- Women said that they had good access to written and verbal information should they need it. They said that they could ring a midwife from their geographical team and usually had a timely response.
- Written information, in the form of a number of advice leaflets, was given to patients when they left hospital. These were discussed with women before they left the unit.
- Information regarding how to make a complaint about the service was available on both the post natal and antenatal wards.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Midwives and doctors understood the need to ensure that patients had the capacity to consent to care and treatment. Doctors said a best interest meeting would be held if a woman did not have the capacity to consent, including for gynaecological operations.
- Consent forms were specific for the procedure being carried out. Those we saw had a section that was given to the patient; however, this part did not have the procedure listed. This meant that the woman did not have a complete copy of their own consent form.
- Consent forms for termination of pregnancy contained the necessary information and the signature of two doctors. They were completed at an appropriate time in the discussion.
- There had been an issue with the consent for histology tests to be carried out on human tissue. As a result of an investigation, the consent forms had been changed and now made the procedures clear.
- Staff were aware of the Mental Capacity Act and deprivation of liberty safeguards and could access the policies regarding these should they need further information.

Are maternity and gynaecology services caring?

Good

Staff treated women with dignity and respect and were kind and polite in their interactions. They understood when women may need additional support due to emotional circumstances and systems were in place to provide this internally or through links in the community.

Women said that they were involved in their birthing plans and their choices were listened to and acted upon. This was not always reflected in written records.

Compassionate care

- Women said that the midwives and doctors had been very kind, caring and patient. We saw staff interacting with patients in a way that protected their dignity and respect. They were friendly and informal in their approach while being polite.
- The results of the CQC survey of women's experiences of maternity services in 2013 were comparable with those of other trusts.
- When staff were discussing women's care and support, for example during handover, they spoke about them in a dignified manner using respectful language.
- The trust provided termination of pregnancy services for foetal abnormalities only and not for social reasons. Staff in the antenatal clinic said that, if a woman self-referred to that unit and requested a social termination, they would be referred to a local clinic or private provider or back to their GP. Should they be vulnerable in any way, for example a teenager, then clinic staff would provide the support and assistance they required to ensure that they were transferred safely to another service.

Understanding and involvement of patients and those close to them

- There was an emphasis on normalisation for women, especially during labour. This meant that midwives

promoted a more natural birth, reducing unnecessary interventions and allowing women to be in a position of their choice for birth, for example. Women told us that they had been involved in their birth plans, although this was not evident in the documentation we saw.
- Partners could visit all day and we saw that they were welcomed onto the ward areas. Other visitors had access twice daily for an hour each time. Midwives said that if there were exceptional circumstances and a patient would benefit from additional visiting, this would be accommodated.
- Women and their partners told us that their opinions and choices were listened to and taken into account, during their antenatal care, labour and postnatal care.

Emotional support

- Midwives and doctors had an understanding of the needs of women with mental health needs.
- There were links with the local authority mental health team, voluntary agencies and support groups. Midwives could refer women directly to the Improving Access to Psychological Therapies Service for support.
- The mental health of women was assessed four times during their care, with the first time being at their first appointment. Should there be any concerns regarding anxiety or depression, a referral would be made at that stage.
- We saw that additional support was provided for women who may require it due to known mental health issues. This was both through increased contact with friends and family and via prearranged postnatal care.
- Facilities were available for bereaved parents and information regarding counselling was provided.

Are maternity and gynaecology services responsive?

Requires improvement

There were no inpatient beds used specifically for patients undergoing a gynaecology operation or termination of pregnancy. They could be accommodated in a mixed ward but this did not protect their dignity or the potentially sensitive nature of the support they would need. A high number of gynaecology operations were cancelled at short notice. There was no plan in place to improve the gynaecology services provided.

The maternity services had an active presence in the community with a variety of representatives from the community on the maternity services liaison committee. They contributed to the development of the maternity services and participated in multidisciplinary meetings. The team midwife approach resulted in patients having continuity of care and support. There had been no complaints in the past 12 months in the maternity services. This was the only service in the hospital with this record.

Service planning and delivery to meet the needs of local people

- The area covered by the trust was geographically spread across Cheshire. The team midwife approach meant that patients could be seen in the community, without the need to travel to hospital, while receiving continuity of care if they were an inpatient.

Access and flow

- The layout of the maternity unit provided separate areas for antenatal, labour and postnatal women. Women could remain in their area or move around the unit as their labour progressed. The neonatal unit was a separate section of the labour ward that allowed for rapid access. The obstetric theatres were immediately across the corridor, which meant that there was rapid access in an emergency.
- A telephone triage service was used to assess whether admission was required. We saw that this consultation was not always recorded.
- The focus was on normalisation and for women to be admitted to hospital only if absolutely necessary and then for the shortest possible time.
- The bed occupancy was below the England average at 47% in the last three months.
- Women who were booked to be admitted to the hospital for induction of labour rang the ward in the morning to ensure that they could be admitted. We saw that in some instances patients were told to ring later in the day as staffing may not have allowed them to be admitted. One woman said that they had not been informed that the inability to be admitted may be a possibility and found this distressing. This meant that the policy of planned admissions was not made clear to all women and could be affected by staffing levels.

- The maternity unit had closed on one occasion in the past 12 months. This had been due to a lack of qualified neonatal nurses and the inability to safely staff that unit. As a result, additional midwives were completing the neonatal nurse qualification.
- Medical staff said that the cancellation rate of operations for gynaecology procedures was high. The trust had cancelled 18 on the day of the operation and 26 one day before in the past 12 months. This was due to a lack of inpatient beds and theatre availability. This meant that these women suffered last-minute cancellations and extended waiting times.

Meeting people's individual needs

- There were no specific beds within the hospital for gynaecology patients. This meant that women requiring a termination of pregnancy due to foetal abnormality might need to wait for a bed to become available before that service could be offered. One patient had waited two days after making their decision following tests. This meant that women had to wait, potentially in a distressed state, because of a lack of available beds.
- Women having a termination of pregnancy would be accommodated, if possible, in the women's unit on ward 2. If there were no beds available they would be in a side room or the main ward area of ward 1A. This was a mixed ward and male patients would be present in communal areas. Patients used the communal toilets and bathrooms. This did not protect the dignity or emotional needs of women who had undergone a termination of pregnancy.
- If a woman required additional support, due to mental or physical health needs, this would be provided by either professional staff or informal carers. We saw that, where a woman would benefit from extra family support, this was facilitated by ward staff.
- The recovery of women following operations was carried out in an open area shared with the main theatres. This meant that a woman with a healthy baby following caesarean section could be in the same room as a woman who had undergone a surgical procedure following the loss of a baby, or termination due to foetal abnormality. This did not respect the emotional loss of the woman and was not sensitive to their needs.

Learning from complaints and concerns

- There had been no complaints in the past 12 months in the maternity services. This was the only service in the hospital with this record.
- Staff said that, if women disclosed any unhappiness or dissatisfaction with the service, they would discuss it with them immediately and resolve it if possible or pass it on to their manager. They believed that this intervention at an early stage had assisted in their record of no complaints.

Are maternity and gynaecology services well-led?

Requires improvement

There was no clear vision or strategy to improve or develop gynaecology services within the hospital. The trust provided information regarding the strategy for gynaecology services but staff within the service were unaware of both the strategy and any of the development plans in place. There was a lack of monitoring of day-to-day procedures and this had led to poor practice not being identified or rectified. Not all areas of risk had appropriate assessments in place or actions to reduce those risks. The trust had identified the need to plan to sustain maternity services and had identified several actions. However, senior midwifery staff did not identify these plans when we spoke with them.

There was active participation by service user groups and an open culture that led to the inclusion of those wishing to be part of the development of the service. Staff said that the leadership of the maternity services was supportive and emphasised their personal and professional development. There were examples of future visions for parts of the service, with improvements and participation in regional projects under way.

Vision and strategy for this service

- The senior midwives and managers had a clear vision for moving the maternity services forward in terms of introducing more specialist antenatal clinics and actions to decrease caesarean sections and to support the professional development of midwives. However, not all midwives were aware of the vision for the service in the future.

- There was no clear vision or strategy to improve or develop gynaecology services within the hospital. The trust provided information regarding the strategy for gynaecology services but staff within the service were unaware of both the strategy and any of the development plans in place.
- The trust had identified the need to plan to sustain maternity services and had identified several actions. However, senior midwifery staff did not identify these plans when we spoke with them.

Governance, risk management and quality measurement

- There was a midwife with responsibility for managing the risks and governance within the maternity services. They collated and shared information from various sources regarding risks identified and actions required.
- There were some areas of potential risk that did not have an assessment completed or adequate measures in place to reduce risks. This included the environmental wear and tear, which resulted in infection control risks, and the provision of one net for use in two birthing pools in the case of emergency evacuation.
- There was a lack of monitoring of the day-to-day procedures and practices in the maternity services. This resulted in managers presuming that staff were working in accordance with the policies and their own codes of practice, without checks being in place. An example of this was the daily procedure for checking controlled drugs, which had not been carried out correctly since September, with records being left blank.
- Monthly meetings of the clinical governance committee for maternity and women's services were held. This was a multidisciplinary committee that discussed issues affecting the provision and quality of the service, such as incidents, updates on action plans and outcomes of audits. Any necessary actions were allocated and followed up at the next meeting.
- A maternity quality dashboard had been introduced and included patients' perceptions of issues such as noise at night, the Family and Friends Test responses, infection control issues and the safety thermometer. Outcomes were communicated to staff, with actions to be taken, in the communication book. Improvements were measured monthly.

Leadership of service

- The head of midwifery and women's services had their office on the main corridor of the maternity unit. They were visible on the maternity wards and staff said that they could discuss issues with them, formally or informally, as appropriate.
- Staff spoke highly of the support they received from all the midwives with a lead responsibility. They said that they had clear lines of accountability and knew who to approach for advice and support.
- Midwives had opportunities to develop their own leadership skills within the service. Those who wished to develop these skills could lead on part of the service for six months. This included incident reporting and investigation, audits, and the off-duty rota. They said that they welcomed this as an active part of their personal development into leadership.
- The responsibilities for leadership and development of the gynaecology service was less clearly defined and recognised by staff. This was due to the lack of a specific environment for the provision of these services and recent changes in the management structure of them. This meant that the responsibility for improving these services was less clear.

Culture within the service

- Staff said that they could discuss any issues regarding practice with their colleagues, line managers or any other person in a position to support and assist them. They described a culture of openness where challenge and frank dialogue was welcomed within the team environment, including between consultants, doctors and midwives.
- Consultants told us that the way of working on the maternity wards was one of teamwork and collaboration, where everyone's views were recognised as being valid.
- Staff said that the teamwork was "excellent" and described how the flexibility of colleagues and the emphasis on providing the best possible service for women meant that they enjoyed working in the maternity unit.
- Many midwives had worked in the unit for a number of years and said that this was because of the open atmosphere and the opportunities for personal and professional development.

Public and staff engagement

- There was a very active maternity services liaison committee (MLSC) at the trust. This consisted of women with an interest in supporting the service, consultant obstetricians, midwives and a GP. They met every three months and discussed issues specific to the delivery of maternity services at the trust. They had been involved in choosing colours for the refurbishment of the labour unit and assisted ongoing work such as increasing the breastfeeding rates by providing a buddy system.
- In conjunction with the family nurse partnership, a young person was to be invited to join the MLSC to represent young mothers.
- A member of the MLSC was also on the maternity ward forum group. This multidisciplinary group met monthly to discuss the performance of the maternity unit and to share ideas for development.

Innovation, improvement and sustainability

- There was involvement in some North West regional initiatives for improvement, such as the development of the morbidly obese pathway of care. This showed an enthusiasm for sharing good practice and developing links with the wider health community.
- Staff told us that they could be innovative and bring ideas to fruition with the support of their supervisors. This included the development of an information and guidance pack for junior midwives about the system of team midwifery.
- There were no long-term plans for the sustainability of maternity services. Managers said that their future was linked to the neonatal and paediatric provision in the hospital in order to ensure safe care for babies.

Services for children and young people

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

Information about the service

Services for children and young people consisted of an inpatient ward, outpatient services and a specialist care baby unit situated within the maternity department. This unit had the ability to support a maximum of eight babies, had one intensive care bed and the ability to provide high-dependency care. The unit accepted babies born at 31 weeks and over. Babies outside these criteria were transferred to other units as part of existing protocols.

The children's ward and children's outpatient services were based on the ground floor and were located together. The ward provided care for up to 21 children, including day cases, inpatients and children admitted for observation. The observation area was open between the hours of 8am and 8pm. The unit had single cubicle bed provision and six bedded bays. There were some parents' facilities and play areas on the ward.

During the announced inspection we visited children's inpatient and outpatient areas and the special care baby unit. We spoke with 12 parents and five patients. We spoke with a range of staff including four consultants, five doctors, 20 nursing staff and 11 allied healthcare professionals. We visited the children's ward as part of an unannounced inspection and spoke with seven members of nursing staff.

Summary of findings

During our inspection we identified serious concerns with the storage of breast milk and the inappropriate storage of contaminated equipment with clean equipment. We raised our concerns immediately with the trust. We reviewed the action the trust had taken as part of our unannounced inspection and were assured that the trust had taken the necessary steps to address our concerns. However, we identified other concerns in relation to infection control; these included the decontamination arrangements for toys in the inpatient and outpatient areas and cots on the special care baby unit. We also found that staff were unclear about the decontamination arrangements for a breast bump. As a result the matron for the service asked the breastfeeding team to review the process. We found that patient notes were not stored appropriately in the outpatient setting. We also found gaps in clinical records relating to medication, demographics, growth charts and individualised care plans.

The environment and layout in the children's ward were such that some parts of the unit were unobservable. There was no evidence of risk assessment when placing children and young people in these areas. We were also not satisfied that monitoring arrangements relating to escalation processes, staffing levels and patient acuity were robust. We raised our concerns with the trust at

the time of the inspection. We returned to the ward as part of our unannounced visit and were satisfied that new procedures had been put in place to address our concerns.

We found that, while there were ongoing discussions regarding healthcare provision, there was no clear vision or strategy in place for children's and young people's services. Staff were passionate about continually improving children's and young people's services.

Audits and monitoring of areas such as medical records and infection control had not identified the concerns we raised during our inspection. Staff knew how to report incidents but some staff told us they did not always report incidents using the electronic reporting system. For example, when levels of care changed on the ward.

Parents and young people told us that they felt safe, informed and supported by trust staff. Throughout our inspection we saw children and young people being treated with dignity and respect. We observed staff providing compassionate care.

Are services for children and young people safe?

Inadequate

During our announced visit we were not satisfied with the storage of breast milk and we observed contaminated equipment from elsewhere in the hospital stored unsafely with clean equipment and clean baby cots. This presented a risk of cross-infection and harm. These issues were immediately brought to the attention of the senior team and the trust executive team. We reviewed this as part of our unannounced visit and were satisfied that the trust had put measures in place to minimise the risks associated with infection prevention and control. We also found that staff were unclear about the decontamination arrangements for a breast bump. As a result the matron for the service asked the breastfeeding team to review the process. Following this and a discussion with the matron we were satisfied that staff were able to use this equipment competently.

We were unclear about the decontamination arrangements for toys when there were staff shortages in the children's inpatient and outpatient areas. We identified that, due to a lack of available space, the decontamination of cots was difficult on the special care baby unit. The environment and layout in the children's ward were such that some parts of the unit were unobservable. There was no evidence of risk assessment when placing children and young people in these areas. This was raised with the trust at the time of the inspection. We reviewed this as part of our unannounced visit and were satisfied that the trust had put measures in place to minimise these risks.

There were monitoring arrangements in place to audit the management of notes; however, we found that patient notes were not stored appropriately in the outpatient setting. We also found gaps in documentation held in clinical records relating to medication, demographics, growth charts and individualised care plans. Staff had received training in children's safeguarding at level three. However we found inconsistencies in staff's knowledge regarding the process of where to record, access and monitor patient alerts and of information relating to children and young people.

Processes and procedures relating to the training and assessment of staff in using CPAP respiratory equipment

were not robust. We raised these concerns with the trust at the time of our inspection and were advised that this was covered on the annual paediatric study day. This did not support what some staff told us during our inspection about their confidence in using this equipment. We have asked the trust to take action to ensure that staff are confident in using all equipment. Since rising this with the trust both the training and assessment processes have been strengthened.

We found that delays in transferring sick children who require a higher level of care in a partner organisation were not recorded via the incident reporting system unless they resulted in sub-optimal care. This meant the number of recorded incidents may not accurately reflect the number of occasions there had been a delay in transfer (regardless of outcome).

The trust had established monitoring arrangements in place for measuring staffing levels and it had undertaken a staffing review based on levels versus acuity earlier in the year. The review used a recognised staffing tool and was based on a pilot for paediatric areas. During our visit we observed that patient acuity was such that the numbers of staff on shift were not in line with the Royal College of Nursing guidelines. We could not find evidence that patient acuity was assessed to ensure appropriate staffing levels. This was immediately brought to the attention of the senior team and the trust executive team. We reviewed this as part of our unannounced visit and were satisfied that the trust had put measures in place to assess acuity and staffing levels appropriately.

Incidents

- Incidents were reported and monitored though a centralised electronic reporting system.
- All staff we spoke to knew how to report an incident. However, some staff told us that they did not always report incidents using the electronic reporting system, for example when levels of care changed on the ward and when gaps in medical staffing were supported by consultants.
- We found that delays in transferring sick children who require a higher level of care in a partner organisation were not recorded via the incident reporting system unless they resulted in sub-optimal care. This meant the number of recorded incidents may not accurately reflect the number of occasions there had been a delay in transfer (regardless of outcome).
- The trust reported 63 incidents relating to the special care baby unit between January 2014 and October 2014. Of these, 60 were reported as 'no harm', two as 'low harm' and one as 'moderate harm'. Forty-one incidents were related to unanticipated transfers into the unit; these included the low and moderate harms reported. Three related to transfers to other units.
- Staff told us that learning from incidents was cascaded using posters, briefings and meetings, as well as handovers, which had a section on 'top tips'. At the time of our visit a locally created staff newsletter was being developed for the children's ward and we were advised that plans were in place to include lessons learned from incidents.
- A staff member told us that the special care baby unit was reported as being closed in May 2014 due to shortages of appropriately trained staff. This was confirmed in the incident report relating to this. Staff told us that there was now a robust rotation of all band 5 staff onto the neonatal course to ensure that all staff had the appropriate qualification to support the unit. Staff felt that this had improved the skill mix on the unit.
- Issues with laboratory specimens clotting had been reported by a number of medical staff; they stated that there had been issues on at least four or five occasions over short period of time. While they were not able to provide a timeframe, we were told that this had been a problem over the previous few weeks. These reports related to both the special care baby unit and the children's ward. Staff stated that this had been raised as an incident. However, when we met with laboratory management they were not aware of any concerns relating to clotted sampling from children's and young people's services. Laboratory staff agreed to discuss concerns raised and to provide further training to staff.
- Children's and young people's services had processes in place to undertake mortality and morbidity case reviews should this be required as part of governance arrangements.

Cleanliness, infection control and hygiene

- All staff had completed infection control training. Compliance data reported that 90% of children's nursing staff were up to date with infection control training, 92% of medical staff and 100% of special care nursing staff.

Services for children and young people

- There were no reported cases of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) for children's and young people's services.
- During our visit we found all ward and outpatient areas to be clean.
- We found a weekly schedule in place for cleaning equipment that had been completed at the time of our visit.
- During our inspection we found toys to be cleaned appropriately but were unclear about how this was monitored or recorded. Staff told us that toys in the children's ward were cleaned by play specialists as part of their role. There were no play specialists on shift for the duration of our visit. The play room was supported for short intervals in the morning only by volunteers and there was no evidence that cleaning of the toys had taken place.
- Staff followed hand hygiene practice in line with local and national policy. We observed staff using personal protective clothing appropriately.
- At the time of our inspection, children's and young people's services were achieving trust compliance standards for hand hygiene. Between April 2014 and November 2014 the children's ward reported 100% compliance.
- An established audit programme was in place for reviewing infection control and cleanliness in clinical areas. The children's ward was assessed in October 2014; this assessment had identified minor work to be undertaken in bathrooms relating to sealant replacement. This reflected what we saw during our visit. On reviewing the latest ward meeting minutes, we saw that staff had not received the latest audit report.
- During our visit we observed that children's breast milk was being stored unsafely in the staff fridge with other consumables such as milk and sandwiches. This was raised at the time of the inspection with the matron for the area. We were advised that it was being stored there due to a fridge being broken; during our visit breast milk was segregated further. A staff member told us that the fridge had been broken for about one month. We found no risk assessment relating to the temporary storage of breast milk. Staff were not aware whether this had been raised as an incident. The fridge that breast milk was being stored in was accessible to staff and the public. There were no monitoring arrangements in place relating to temperature recording or cleaning arrangements for the fridge.
- A parent told us that the breast pump on the paediatric ward was not working properly and they felt that staff did not know how to use it. We reviewed the breast pump on the children's ward and found staff were unclear about the cleaning arrangements for this piece of equipment. We discussed this with the matron for the area who provided assurance relating to procedures in place for decontamination of this piece of equipment. In addition, as a result of staff being unclear about the arrangements, the matron for the service asked the breastfeeding team to review the process. Following this we were satisfied that staff were able to use this equipment competently.
- We found four used mattresses labelled as having been used on other wards and requiring specialist cleaning due to potential contamination, including one labelled 'used MRSA', stored in an unsealed bag on the floor in a large unlocked room that was used for staff breaks and staff handover and was an access point for staff to offices. This room was also being used to store three pieces of equipment that were labelled as having been cleaned and ready for use, including baby cots. This area was part of the children's ward that was not observable and was accessible to children, young people and their families.
- This was reported to the trust, which removed the mattresses. We visited the area as part of our unannounced visit and did not find any mattresses stored in this area. The matron confirmed that since the visit this area was checked daily to ensure that all items stored there were appropriate.
- The special care baby unit had procedures and monitoring arrangements in place to clean equipment daily and in between use. During our visit we observed good practice relating to the cleaning of most equipment. We observed that, due to a lack of suitable space for cleaning, staff used a desk in the centre of the unit on which to place cot parts during the cleaning process and laid towels across it in order to mitigate infection risks. This practice presents a risk of cross-infection and potential harm. There was no risk assessment relating to this practice. We found procedures in place for staff relating to the cleaning and monitoring of equipment; however, we did not find specific detail relating to this practice.
- A programme of training and assessment was in place for 'aseptic no touch technique' (ANTT) and during our visit we observed staff undertaking ANTT correctly.

Services for children and young people

Environment and equipment

- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. Daily safety checking protocols for emergency equipment were in place and up to date.
- Equipment was checked on a weekly basis and further checks were in place on the special care baby unit; these were supported by the hospital sterilisation and decontamination unit (HSDU).
- The children's ward was designed on a 'U' shape template, with three single rooms located on the opposite side of the ward from the nurses station. These rooms were not observable and were some distance away from the nurses' station. Staff advised us that children who were low risk would be placed in these side rooms. However, we could not find risk assessments relating to decision making at the time of our visit. Staff told us that decisions were based on clinical judgement.
- During our visit, a parent advised us that their child had been nursed in an unobservable room prior to deteriorating suddenly and then required significant respiratory support. This was raised at the time of the inspection with the trust, which undertook an investigation into the case.
- The staff kitchen was located in an unobservable area of the paediatric unit. This area was not locked and was accessible to children, young people and their families. We observed that crockery was stored at a low height and cutlery was accessible. During our visit we observed a child trying to access the kitchen while under the supervision of their mother.
- We raised these concerns with the trust during our visit. We reviewed what action the trust had taken as part of our unannounced visit and found that the kitchen was locked securely.
- There were no plug protectors in place within the children's ward.
- On the special care baby unit, chlorine-based cleaning products used for cleaning baby bottle equipment were stored in the open clinical setting and were easily accessible and not stored in an appropriately secured area.
- Within the ward area, some cupboards in clinical areas were not locked. On reviewing one cupboard we found that sharp equipment was readily accessible. This was identified to staff at the time and appropriate action was taken.
- The cleaning cupboard with plastic storage bags was accessible to children and young people.

Medicines

- A dedicated pharmacist was available for children's and young people's inpatient services. Staff told us that this role supported judicial prescribing and administration.
- Reporting arrangements were in place to monitor medication incidents. Data provided by the trust for 12 months identified that 10 incidents were reported for the children's ward, of which seven were 'very low harm' and three were 'low harm'.
- The trust reported that there were four medication incidents in the last 12 months relating to the special care baby unit, of which three were 'very low harm' and one was 'low harm'.
- Staff were trained appropriately in medicines administration as part of their preceptorship and the paediatric mandatory study days and as part of undertaking a neonatal specialist qualification.
- We reviewed one drug chart and observed that intravenous administration of antibiotics had been delayed by two hours. Staff advised us that the delay was due to a wait for blood results. We reviewed the medical notes for the child and noted that the blood results had been recorded three hours previously. We spoke with staff regarding medication incident reporting and some were not clear that a delay in medications would be reported.
- We reviewed a drug chart at 3pm and noted that there was no signature against a drug that was prescribed for administration at midday. We asked staff on the ward about this and we were advised that the drug had been given but not signed for. The inspection team witnessed this drug being signed for at 3pm. The team observed that staff on this shift were busy due to the acuity of children at the time and this was reflected in the pressures observed.
- We observed a prescription chart for a topical skin cream that on six occasions was not signed for.
- We reviewed drug charts in the special care baby unit; all records were complete with stop and review dates evident.

- The special care baby unit was supported by a pharmacist. As part of that role, evidence of prescription validation was recorded.
- A copy of the national formulary was accessible in all children's and young people's services to support prescribers.
- Daily monitoring was in place for fridge temperatures to ensure the safe storage of medicines in both the children's ward and special care baby unit.

Records

- The trust had a clinical records management policy in place which stated that: "When not in use medical records are stored in a place that ensures confidentiality, i.e. a locked cupboard or locked room/ area."
- Monitoring arrangements were in place to provide assurance regarding clinical records management. Children's outpatients scored 100% in a records audit relating to confidentiality undertaken in June 2014.
- We visited the children's outpatient area at 9.30am. We observed medical notes stored in two clear open boxes on the floor of the waiting area by the door. Staff told us that these notes were awaiting collection following clinic. There were two families in the waiting room at this time and reception staff were also in the area. We returned to the paediatric outpatients department at 4pm and it was possible to access the unit where notes were still accessible in the clear boxes on the floor in the waiting room.
- During our inspection we observed that paediatric case notes were not always returned to the notes storage area, but were left in the nursing or reception area. We observed that the nursing and reception areas did not always have staff located at the station, meaning that records were left unattended.
- On the first day of our visit, clinics were supported by a bank member of clinical staff and on the second day there was a shortfall so a member of ward staff attended the outpatient area to support the service. This member of staff was still being shown as supporting the children's ward on the staffing information board.
- We observed an apnoea record in a child's notes that had no date recorded and records on an nasogastric chart were incomplete between 10 December 2014 and 11 December 2014.
- We reviewed four records and found one completed growth chart. Nursing staff confirmed that nursing staff recorded the weight of children and young people but that it was the doctor's responsibility to complete a growth chart assessment. We spoke with two consultants who agreed that it was the doctor's responsibility to complete this assessment.
- We reviewed five sets of case notes and noted that family history, full name and date of birth were not recorded in four instances

Safeguarding

- The director of nursing led safeguarding arrangements for the trust. Children's and young people's services had a designated named doctor and nurse. A non-executive lead had recently been identified for future safeguarding trust meetings.
- The trust had governance reporting arrangements in place for safeguarding that included both children's and adult's services. Between June 2014 and November 2014 the trust made 57 referrals to children's social care and attended 117 case conferences.
- The trust had representation at external strategy meetings and robust links with the multi-agency risk assessment conference (MARAC).
- An audit programme was in place for safeguarding children and was monitored through the trust safeguarding committee. For example, in June 2014 the trust undertook an audit of young people attending accident and emergency and presenting with self-harm or drug and alcohol concerns. Of 279 attendances, six children and young people attended due to self-harm or drug and alcohol issues.
- Level three safeguarding training figures supplied by the trust showed that 89.7% of children's ward staff were up to date with training and 89.5% of staff in the special care baby unit were up to date.
- All staff knew who the named nurse was for children's safeguarding and knew how to access this service. Staff told us that training included serious case review discussions and learning.
- We found accessible safeguarding flow charts and referral information available in all clinical settings.
- The trust had a supervision policy in place and staff were aware of how to access this.
- There was a process for safeguarding peer review undertaken bi-monthly. Medical staff told us that they found this supportive.
- There were inconsistencies in staff understanding of what process was followed in relation to recording

information on children and young people with safeguarding concerns and child protection plans. We were not assured that staff were following the same process and there was potential for a patient alert or other documentation to be missed.

- The lead safeguarding nurse told us that a new system had been put in place a number of months previously using a front sheet in the case notes. We reviewed one record where a child protection case conference had been undertaken and found that the patient alert sheet had not been completed; we also noted that nursing records stated that there was no social worker allocated. This supported what staff told us about the new process not being fully embedded.
- We spoke with two nursing staff members who were unclear about parental responsibility and where to access details regarding this.
- The special care baby unit had robust monitoring arrangements in place using a paper system that linked to the Cheshire and Merseyside neonatal unit network, called the 'Badger network'. A checklist system at the point of discharge was in place to ensure that all appropriate people were notified of any arrangements in place relating to safeguarding and child protection.
- We found robust arrangements in place for providing information on child protection plans to clinics seeing children and young people, such as orthopaedics and audiology.
- The trust had developed links between adult and children's services relating to the screening of adults (possible parents, relatives or carers of children) for alcohol and drug concerns. The named doctor for children's safeguarding felt that this had strengthened partnership working.
- A programme of support for trainees undertaking clinical examinations relating to children's safeguarding was in place within the trust and consultant assent was used in order to review and agree findings. One trainee advised us that this did not always happen out of hours. However, this did not reflect what we were told when we spoke to other members of the team. All staff were clear about the process to be followed to obtain consultant assent.

Mandatory training

- Mandatory training was delivered locally through children's and young people's services.
- Staff were up to date with mandatory training and this was reflected in the records we reviewed. The most recent mandatory compliance data reported that 90% of children's nursing staff were up to date with mandatory training and 92% of medical staff were up to date, while 100% of special care nursing staff were up to date with mandatory training.

Assessing and responding to patient risk

- A Paediatric Early Warning Score (PEWS) system was in place on the children's ward based on the NHS Institute for Innovation and Improvement PEWS scoring system.
- Staff were assessed as competent to use this tool and there was a process for new members of staff to be trained as part of their induction.
- We observed that, for two children requiring respiratory support using specialist equipment (continuous positive airway pressure or CPAP), observations were recorded but PEWS scoring was not completed. Staff told us that this was due to the monitoring arrangements in place for children while on CPAP.
- During our visit we observed three children requiring CPAP support. We observed a newly qualified member of staff supporting two children on CPAP. The staff member told us that they were supported but they were not aware of how to use the CPAP equipment. We observed that they were being supported appropriately by a senior member of nursing staff.
- A senior nurse told us that they did not know who had been assessed as being competent to use CPAP equipment. We reviewed information relating to medical device competency held in staff records. We noted that staff completed a self-assessment on equipment and competency. Two staff members told us that they did not feel confident using specialist respiratory equipment and one member of staff felt that refresher training would be useful prior to the winter period.
- We raised concerns with the trust relating to competence and confidence of staff using CPAP machines and were advised that this was covered on the annual paediatric study day. This did not support what some staff told us during our inspection about their confidence in using this equipment. We have asked the trust to take action to ensure that staff are confident in using all equipment .
- During our announced visit we could not find evidence of an escalation plan relating to staffing levels and

patient acuity, and therefore we were not assured that processes were in place. This was raised with the trust at the time of the inspection. When we visited the ward again as part of our unannounced inspection we were satisfied that robust arrangements were in place to support patients and staff. Staff told us that they found the new arrangements supportive.

- During our visit we observed the deterioration in a child's condition requiring respiratory support. We observed timely responses to care needs from all staff involved. However, on reviewing the child's case notes we noted retrospective entries and a timeline that suggested possible delays in opportunities to escalate concerns. The entries in the case notes did not reflect what staff told us in terms of escalation of concerns to medical staff. This was raised with the trust immediately. Following our inspection, the trust carried out a full investigation of this incident. The investigation report highlighted the need to improve record keeping.
- The care dependency on the ward changed quickly and this was not always reflected initially in the staffing numbers. On discussion with staff, it was identified that staffing requirements were difficult to predict but that shortfalls were filled by existing staff in the short term.
- We observed four medical and nursing handovers during our visit and found that these meetings were well led and clearly identified children and young people at risk of deterioration.

Nursing staffing

- Nurse staffing for the children's ward and special care baby unit were monitored and reported to the director of nursing as part of safer staffing reporting. We found that staffing on the children's ward was currently under review and that levels had been changed to support the ward manager becoming supernumerary. This was supported by board papers from March 2014.
- In 2014, the trust had undertaken a staffing review using a recognised staffing tool. In terms of dependency levels, the children's ward was benchmarked and was in line with other children's services with similar characteristics.
- The review recommended 28 whole-time equivalent (WTE) nursing staff. At the time of our visit the trust reported that there were 25.3 WTE staff. On reviewing this report, we found that the difference in figures related to healthcare assistant numbers. Day case surgery was also included as part of the review.
- There were four trained nurses on shift in the morning and three in the afternoon. Medical and nursing staff told us that staffing levels had improved compared with the previous year.
- During the second day of our visit there were 14 children and young people on the children's ward, two of whom were receiving respiratory support in line with high-dependency care. On the morning of our visit there were four trained staff on duty, of whom two were newly qualified staff and one was a healthcare assistant. There were plans to reduce afternoon staffing to three trained staff and one healthcare assistant with the same level of dependency; this would not be in line with Royal College of Nursing recommendations. Following our inspection the trust carried out an investigation, which included a review of staffing levels on the children's ward during our inspection, and found levels were appropriate for the needs of patients.
- During both our announced and unannounced visit we observed fluctuations in care dependency on the ward ranging from under-occupancy to care dependency that exceeded the number of staff on duty. Staff told us that shortfalls were mostly covered by ward and outpatient areas' own staff and that there was a supportive culture relating to staffing shortfalls. We noted that the ward manager worked beyond their shift duration on two days of the inspection and that senior staff were used to fill shortfalls. The trust was aware that this was occurring. From information supplied by the trust, the last incident report relating to staffing levels had been on 5 July 2013. In this instance the trust reported via the Strategic Executive Information System (STEIS) that the children's ward was closed to admissions.
- During our visit, the children's outpatients department was staffed by bank staff but on the second day, due to sickness, a member of the ward staff supported the outpatients department at short notice. This in turn affected staffing levels on the children's ward.
- Senior medical staff confirmed that staffing the special care baby unit could be challenging as the dependency of babies on the unit could change very quickly and, while some things could be planned for, staffing requirements could be impossible to predict.
- We reviewed incidents relating to staffing for the special care baby unit. There were four incidents of staff shortages covering the special care baby unit reported between March 2013 and July 2014. One incident related to there being no band 6 nurse on the night shift.

- Staff on the neonatal unit told us that staffing on the unit could be very frustrating. They gave examples of when staff had had to extend their shifts so that the unit had staff on duty trained in neonatal care. The trust was aware this was occurring.
- We reviewed staff rotas for the neonatal unit and noted that over a period of 17 days on 11 occasions the neonatal unit was supported by staff from the maternity unit.
- We reviewed information available relating to bank and agency staff. The special care baby unit had reduced its usage of such staff from 3.1% in March and April 2014 to 0.8% in August 2014. This supported what staff told us in relation to staff supporting shortfalls within the unit
- Staff turnover in the special care baby unit in August 2014 was 6.9%; in comparison, in April 2014 staff turnover was shown to be 12.9%. The children's ward reported that staff turnover in August 2014 was 3.3%, whereas in April 2014 it had been 9.7%.
- Records relating to staff sickness identified that both the children's ward and the special care baby unit were below the trust average. The trust reported that its 20-month cumulative score showed the trust average at 4.5%; the figure for the children's ward was 3.9%, the special care baby unit 2.9% and medical staff 1.4%.

Medical staffing

- There were adequate numbers of medical staff to provide safe care for children and young people.
- Medical staffing relating to children's and young people's services was monitored through the trust's risk register. Medical staff turnover increased from 13.4% in April 2014 to 29.6% in August 2014. Staff told us that this related to opportunities in specialty areas in other trusts.
- At the time of our visit there were seven paediatric consultants in post, of whom two were provided by locum cover. We were advised that interviews for permanent posts were being undertaken later in the month.
- Consultants working in children's and young people's services stated that, while at times medical staffing could be challenging, the service was always supported and they all "covered each other". Consultants told us that there were occasions when they would cover gaps in the rota.
- A report from a deanery annual assessment from 2 October 2014 stated that medical staff were delighted with all aspects of their placement, including induction, experience and support. It stated that staff had nothing but praise for the trust. They would unreservedly recommend the post to their peers. This reflected what medical staff told us during our visit.

Major incident awareness and training

- There were business continuity plans and major incident plans in place for children's and young people's services.
- We spoke with some ward staff who were unclear about their responsibilities regarding major incident arrangements. However, we spoke with senior nursing and medical staff who knew their responsibilities in relation to the plans in place.

Are services for children and young people effective?

Requires improvement 

Staff raised concerns relating to their competence and confidence in supporting children and young people with mental health needs. While the provision of suitable training was partly beyond the trust's control, it was unclear what the trust had done to ensure staff were competent and confident in this area.

There had been nine occasions between Sunday 17 November and Sunday 14 December 2014 when the neonatal unit was supported by postnatal staff and a senior member of staff from the special care baby unit. We were advised that these members of staff may not have a neonatal qualification in accordance with British Association of Perinatal Medicine (BAPM) guidelines. We raised this with the trust who assured us that staff members in this situation were supervised and that appropriate staff were chosen to support the unit.

During our visit there were no play specialists available due to sickness and annual leave. A volunteer was running the play room from 9am to midday. Staff told us that staffing this area had recently been challenging due to staff retirement but arrangements were in place to recruit and provide interim support.

There was evidence of multidisciplinary working on both the special care baby unit and the children's ward. Current

best practice guidance was used to inform practice. The trust participated in national audits and peer review and acted on findings to improve practice. Appropriate methods of monitoring pain were in place. Children and young people were offered a choice of meals that were age appropriate and that supported their individual needs.

Evidence-based care and treatment

- Clinical staff on the special care baby unit were active members of regional and national neonatal networks. Regional groups agreed guidelines for shared working and developed audit tools to assist in consistency of approach, and to provide continual improvement of services.
- The children's services had established links with other local trusts. Staff shared learning though networks. This showed that there were working links in place to support staff, children and young people.
- Policies and procedures were supported by evidence-based guidelines.
- The special care baby unit participated in the Bliss baby charter. We noted that there were no wall-filled suction or oxygen points in the family room. This was not in line with Bliss standards. However, we did not observe this room being used for supporting families in preparation for going home.

Pain relief

- Pain relief used age-appropriate methods and both analgesic and non-analgesic interventions.
- Pain assessment was part of the PEWS record.
- Children and young people were supported with pain management following surgical procedures.

Nutrition and hydration

- Children and young people were offered a choice of meals that were age appropriate and that supported their individual needs, such as gluten-free and sugar-free. Children told us that they enjoyed the food. Parents told us that the food was good quality and there was a lot of choice, including healthy options.
- Dietician support and advice were available for children, young people and families supporting children with enteral nutritional needs. Dieticians also provided support to parents and babies with milk allergies and children diagnosed with coeliac disease.
- Breastfeeding advice was available from a specialist team for parents on the special care baby unit. This was also extended to the children's ward.

Patient outcomes

- The trust participated in national audits including those on diabetes, childhood epilepsy, acute kidney injury and neonatal intensive and special care.
- An established audit programme of children's and young people's care was in place; this was driven by national programmes. Audits were monitored through dashboard and governance arrangements.
- The trust participated in peer review of the paediatric diabetes service in 2014. Following this review, immediate and serious risks were identified in relation to pathway arrangements for young people aged 16 to 19 years in diabetic ketoacidosis as well as serious concerns relating to the transition of care to adult services.
- Following this report, the trust had acted on concerns raised and had an action plan and monitoring arrangements in place. We found that transition arrangements and young people-focused clinics were now in place for this age group and a protocol had been developed relating to admission to the children's ward in order to support young people.
- Data provided from hospital episode statistics (HES) for June 2013 to May 2014 identified that there were no readmissions to the trust for children following elective surgery in all age groups.
- Data from HES for July 2013 to June 2014 identified that readmission rates for children and young people with asthma, diabetes and epilepsy were worse than the national average.
- Medical and nursing staff told us that children and young people in these groups were offered direct access to the ward. At the time of our inspection, there were 100 children and young people who had open access to the ward. During our visit we spoke with a family that had open access; they told us that they felt supported by these arrangements.
- We reviewed trust data for readmissions to the children's ward from May 2014 to November 2014 and found that 208 children and young people were admitted via the open access pathway.

Competent staff

Services for children and young people

- Staff told us that they received regular appraisals. Records showed that for the year so far 83% of children's nursing staff had received an appraisal, 80% of medical staff and 80% of neonatal nursing staff. Senior nursing staff told us that all appraisals had been completed since August 2014 and staff records reflected this.
- The trust had a reporting process in place relating to medical revalidation, with the interim medical director as the responsible officer. On 30 September 2014, the trust reported revalidation rates for medical staff at 94%. This reflected what medical staff told us.
- A practice education facilitation programme was in place to support children's and special care baby unit staff; staff said that this was very supportive. This programme included scenario training.
- The data available on children's life support training showed that three anaesthetists had undertaken advanced paediatric life support training and 14 had undertaken basic paediatric life support training.
- Staff raised concerns relating to their competence and confidence in supporting children and young people with mental health needs. While the provision of suitable training was partly beyond the trust's control, it was unclear what the trust had done to ensure staff were competent and confident in this area.
- On nine occasions between Sunday 17 November and Sunday 14 December 2014 the neonatal unit was supported by postnatal staff and a senior member of staff from the special care baby unit. We were advised that these members of staff may not have a neonatal qualification in accordance with British Association of Perinatal Medicine (BAPM) guidelines. We discussed this with the matron for the area who assured us that staff members in this situation were supervised and that appropriate staff were chosen to support the unit. She stated that all staff who were interested in supporting the unit were offered and encouraged to complete neonatal specialist training.
- We found that clinical supervision was completed once a year and staff had access to the maternity supervisor on call.
- We spoke with a new member of staff who had completed the induction programme. They told us that they felt well supported by staff when joining the team. They felt the induction process had been comprehensive and appropriate for the job role.
- A new admission screening tool had recently been introduced; this included tissue viability on the children's ward. Staff told us that they had not received training in tissue viability but that this was planned for February 2015.

Multidisciplinary working

- There was evidence of multidisciplinary working on both the special care baby unit and the children's ward. Staff, children and young people had access to dedicated pharmacists and paediatric physiotherapy specialising in respiratory and orthopaedic care.
- Specialist nurses were based on the ward and were available to support patients, parents and staff. Staff told us that they found this supportive.
- An outreach team was in place to support children and young people at home and to reduce readmissions into hospital.
- Children and young people had access to psychological support though the CAMHS team.
- We observed daily visits to the ward from the health visitor liaison; staff said that this worked very well.
- The diabetes service adopted a collaborative approach regarding consultant provision.
- The trust had a transition board in place with representation from commissioners, medical and nursing staff from acute and community care provision. Examples of transition arrangements were seen for young people with epilepsy and respiratory conditions.
- The trust had no provision for children and young people requiring insulin pump support. However, arrangements were in place with local hospitals.
- We found established local and regional network procedures in place to ensure the transfer of children and young people. During our inspection we observed that, due to pressures in children's services across the region, the ward supported a child requiring intensive care. Staff told us that this was an exceptional circumstance. Following our visit we reviewed the trust investigation report relating to this case and were satisfied that the trust had liaised with regional networks appropriately.

Seven-day services

- A consultant was available seven days a week with cover out of hours provided by an on-call service for children's and young people's services. We spoke with both nursing and medical staff who stated that out of hours it

was trust policy that consultant presence was required within 20 minutes of being notified. Staff told us that on most occasions consultants were on hospital premises immediately and they felt supported by senior teams.
- All children and young people were reviewed by a consultant daily. Once a week, a ward round was undertaken in the special care baby unit that included all medical staff responsible for providing medical cover for the special care baby unit. Parents told us that this was very reassuring as consultants they met for the first time had full knowledge of what was going on and had a full understanding of the management plan.
- Current arrangements between the trust and CAMHS ensured that children and young people using the service were seen on the ward on a Monday, Wednesday and Friday.
- Discussions with staff identified that, while they may be able to refer outside of these arrangements if there was an emergency, at times CAMHS were also under pressure and so patients might not always be seen in a timely manner. When we spoke with both nursing and medical staff it was clear that this caused concern, as children and young people might not always receive prompt mental health intervention by appropriate specialists.
- During our visit there were no play specialists available due to sickness and annual leave. A volunteer was running the play room from 9am to midday. Staff told us that staffing this area had recently been challenging due to staff retirement but arrangements were in place to recruit and provide interim support. We observed children and families enjoying crafts with the play volunteers during our visit.
- Play specialists were not available as part of a seven-day service. Play specialists were not accessible in other areas of the hospital that supported children, such as outpatients clinics held in the adult outpatients area.

Access to information

- Information leaflets were available on a number of health and social topics throughout the children's and young people's service.
- Information was provided in alternative formats and languages, for example Polish and Bengali.
- Health promotion information and access to local services were available for children and young people. During our inspection we observed families accessing this information during their stay.
- Parents told us that they were able to access information easily.
- Ward and outpatient areas had trust policies and procedures that were accessible to staff.

Consent

- Staff were aware of consent procedures in place for children and young people. Staff were aware of the underpinning principles relating to Gillick competencies for deciding whether a child was mature enough to make decisions and give consent.
- Staff had an understanding of trust policies and procedures relating to consent.
- Parents and carers told us that they had been involved in decisions relating to the care and treatment offered.
- We observed staff providing explanations and options to parents to enable them to give informed consent.

Are services for children and young people caring?

Good

Children, young people and their families told us that they felt safe and supported by staff. Young people were included and involved in decision making; we were assured that this was the case through our observations and speaking with young people and their families.

We observed that medical and nursing staff were kind, caring and compassionate. Children, young people and their families told us that: "Staff are fantastic" and "Care is excellent."

Care plans were not always individualised on the children's ward.

Compassionate care

- Parents and young people told us that they felt safe, informed and supported by trust staff.
- Throughout our inspection we saw children and young people being treated with dignity and respect. We observed staff providing compassionate care.
- Feedback collated from both inpatient and outpatient surveys was positive for this service.

Services for children and young people

- Children, young people and families spoke positively about staff interactions and felt supported. It was clear from what parents told us that both the special care baby unit and the children's ward were held in high regard in terms of the care they provided.
- Nurses told us that all staff worked really well as a team and they supported each other at times of pressure. Staff told us that they were very proud of the care that they provided.

Understanding and involvement of patients and those close to them

- Bedside handover had recently been implemented on the children's ward. There was an evaluation process in place for staff and parents to provide feedback and we saw that the handover was modified as a result.
- Handovers on the special care baby unit were undertaken at the bedside. Parents told us that they found this supportive as it provided an opportunity to speak with clinical staff and time to have questions answered.
- Care plans on the children's ward were not individualised. Staff told us that new care plans had been introduced in the previous two months so they were still being embedded.
- Parents told us that they were involved in all decisions made regarding their child's care and treatment; however, on some occasions this was not reflected in the documentation available.
- Health passports were available to identify the needs and preferences of children and young people. Staff told us that they found these supportive.

Emotional support

- Clinical nurse specialists were available in both the ward and outpatient settings to provide emotional support for children and young people.
- The trust had access to psychology services to support people and young people.
- Assessments tools were in place to support children if there were concerns about anxiety and depression.
- There were good links between children's and young people's services and CAMHS; however, staff were concerned that, due to demands on this service, there was a delay in children and young people being seen.
- Staff advised us that play specialist services were invaluable in providing emotional support for children and young people.
- A parent said that, as part of a previous recent admission, the ward liaised well with school services to support continued education.

Are services for children and young people responsive?

Requires improvement

During our inspection we identified concerns in relation to the assessment and management of bed occupancy and patient acuity. As part of our unannounced visit we found that new procedures and checklists were in place for the assessment of staffing and acuity on the children's ward and of any required restrictions to admissions. Daily bed status risk assessments were also in place and we found these to be robust. We were satisfied that the changes put in place ensured that there were regular review processes to ensure that bed occupancy and patient acuity were monitored and reported.

We were not assured that escalation procedures on the children's ward were robust in there was no process in place to review staffing according to patient acuity and need and escalation of staff shortages. We raised concerns with the trust and, following our unannounced visit to the ward, we were satisfied that our concerns had been addressed. Staff stated that they felt supported by the new arrangements.

Due to the lack of available outpatient clinic rooms, an area on the inpatient unit was utilised to support meaning there was an increased flow of children and parents or carers within the children inpatient area. Staff told us that this happened frequently due to the challenges posed by the number of clinics running and the space available. Staff also told us the children's ward environment was not conducive to meeting the needs of children and young people with mental health needs.

Complaints procedures and how to complain were visible and available across children's and young people's services, including information in a child-friendly format. Translation services were available and staff knew how to access them. We found evidence of multidisciplinary case conferences and discharge planning to support children's individual needs.

Services for children and young people

Service planning and delivery to meet the needs of local people

- During periods of increased admissions or staff shortages the special care baby unit had escalation procedures in place.
- Medical staff had established relationships with local hospitals to receive support for severely ill babies and children who needed to be transferred in and out of the unit.
- We were not assured that escalation procedures on the children's ward were robust. We raised concerns with the trust and, following our unannounced visit to the ward, we were satisfied that our concerns had been addressed. Staff stated that they felt supported by the new arrangements.
- The children's ward had single rooms available that were used for teenagers on the unit. At the time of our visit, there were no specific facilities to support young people. Staff told us that discussions were in progress to provide some additional recreational space on the unit but that it was challenging ensuring that children and young people were kept safe while providing privacy due to the layout of the ward.
- Staff told us that supporting children and young people with mental health needs in the ward environment was challenging as the layout of the ward meant that at times these children and young people were nursed in bays with other children so that they could be observed.
- Due to the lack of available outpatient clinic rooms, an area on the inpatient unit was used to support clinics. Staff told us that this happened frequently due to the challenges posed by the number of clinics running and the space available.
- Parents staying for long periods of time on the children's ward had access to a kitchen with designated storage facilities for food. They also had access to hot drinks in this area.
- Parents on the special care baby unit had access to a room with a fridge to store food; however, there were no facilities to make drinks. Parents told us that they had to use the drinks machine located on the other side of the maternity unit, which could be accessed through either the labour or the postnatal ward.

Access and flow

- Between June 2014 and November 2014 there were seven babies transferred into the special care baby unit and 10 babies were transferred out to other trusts. Staff told us that existing arrangements supported the safe transfer of care.
- Between May 2014 and November 2014 there were 3,145 admissions for children and young people between the ages of 0 and 18 years. Of these, 742 were through the accident and emergency department.
- During our visit we identified that 100 children and young people with conditions that required long-term management had open access to the children's ward and that they were admitted on 208 occasions between May 2014 and November 2014.
- During our inspection we identified concerns in relation to the assessment and management of bed occupancy and patient acuity. On our unannounced visit we found that new procedures and checklists were in place to assess staffing and acuity on the children's ward and any required restrictions to admissions. Daily bed status risk assessments were also in place and we found these to be robust. We were satisfied that the changes put in place ensured that there were regular review processes to ensure that bed occupancy and patient acuity were monitored and reported.
- Overall occupancy on the children's ward ran at approximately 54%. However, we found occupancy rates were measured at midnight and so did not include day case numbers. Staff told us that as a result, occupancy levels could fluctuate; this supported what we observed. We were advised that a piece of work was being undertaken to understand bed occupancy in this area.
- There were no children or young people staying on adult wards at the time of our inspection.

Meeting people's individual needs

- A variety of equipment was available on the children's ward including beds and cots in various sizes. Due to the existing building structure on the ward, parents' accommodation was offered next to the bed in a reclining chair or a pull-out bed.
- Due to the existing building structure in the special care baby unit, there was one single room available for parents to use.
- Translation services were available and staff knew how to access them.

Services for children and young people

- Breastfeeding facilities were available across all children's and young people's services. Parents on the special care baby unit had access to specialist advice.
- There was a large variety of play equipment available to accommodate different ages and needs in both inpatient and outpatient areas. Toys could be provided at the bedside as well as games and books.
- Children above five years of age could have surgery at the hospital if required. If this was the case, patients were admitted to the paediatric ward and accompanied by a paediatric nurse in the theatre. The majority of children requiring emergency or major trauma were transferred to neighbouring specialist children's hospitals.
- The theatre recovery areas did not have a segregated paediatric recovery bay. Theatre staff told us that they would maintain privacy by ensuring curtains were drawn. They also told us that they would allow parents or guardians access to the recovery area if there were no other patients present.
- We observed that individual plans for children and young people with complex needs were in place.
- We found evidence of multidisciplinary case conferences and discharge planning to support children's individual needs.

Learning from complaints and concerns

- Governance meeting minutes for October 2014 showed that there were no open complaints relating to this service. This reflected what staff told us.
- Complaints procedures and how to complain were visible and available across children's and young people's services, including information in a child-friendly format.
- We spoke with a family that had previously had concerns and that had been able to get information easily on how to complain and knew what to do.
- Following concerns raised by a family relating to their stay on the children's ward, staff met with the family. As a result, all families now have the opportunity to be involved in a debrief meeting prior to discharge in order to talk through what went well and what could have been improved.

Are services for children and young people well-led?

Requires improvement

We spoke with a number of staff members across services regarding their understanding of what the vision and strategy were for children's and young people's services. We found that, while there were ongoing discussions regarding healthcare provision, at the time of our inspection there was no clear vision or strategy in place for children's and young people's services. Staff were passionate about continually improving children's and young people's services.

During our inspection we were not satisfied that monitoring arrangements relating to escalation processes, staffing levels and patient acuity were robust. We raised our concerns with the trust at the time of the inspection. We returned to the ward as part of our unannounced visit and were satisfied that new procedures had been put in place to address our concerns.

We found that audits and monitoring of areas such as medical records and infection control had not identified the significant clinical risks we raised during our inspection.This meant there was a risk
that information used to provide the trust with assurance and oversight may not have been accurate or reliable.

There was a defined leadership structure in place for both nursing and medical staff. However, nursing staff told us that there had been a significant period of time when there was no matron in post, and that this had had an impact on the workload of senior nurses. Staff told us that both the senior executive team and nursing team were visible in children's and young people's services. Staff felt that managers were approachable and supportive of staff. The service used a variety of methods to obtain patient feedback in order to improve.

Vision and strategy for this service

- Children's and young people's services had previously been reviewed as part of a local healthcare economy review looking at care provision across the area. This included looking at opportunities to develop strategic partnerships with other services in order to provide the best treatment options for children and young people.
- We spoke with a number of staff members across services regarding their understanding of what the

vision and strategy were for children's and young people's services. We found that, while there were ongoing discussions regarding healthcare provision, at the time of our inspection there was no clear vision or strategy in place for children's and young people's services.

Governance, risk management and quality measurement

- During our inspection we were not satisfied that monitoring arrangements relating to escalation processes, staffing levels and patient acuity were robust. We raised our concerns with the trust at the time of the inspection. We returned to the ward as part of our unannounced visit and were satisfied that new procedures had been put in place to address our concerns.
- Risk registers supported the risks that staff had identified. We found monitoring arrangements in place and evidence that risks had been reviewed.
- We reviewed open risks relating to children's and young people's services. The risk register showed that anaesthetic staff had identified a need for support in undertaking advanced paediatric life support or European paediatric life support and associated training needs. It was unclear what action had been taken to address this issue; this risk was due for review at the time of our inspection.
- Medical and nursing staff raised concerns regarding confidence and expertise in supporting children and young people requiring specialist mental health services and support (child and adolescent mental health services or CAMHS). This was reflected on the risk register and has first been identified on 17 October 2013 as a moderate concern. At the last risk register review, a training programme was still to be agreed with the CAMHS team. Trust staff told us that this was out of the trust's control. However, it was unclear what action the trust had taken to mitigate the risk and support staff.
- Audit programmes were in place for monitoring standards of care and these were monitored throughout children's and young people's services. Examples of these were medical records audits and infection prevention audits. However, we found that audits and monitoring of these areas had failed to identify the significant clinical risks we raised during our inspection. For example, we were not satisfied with the storage of breast milk and we observed contaminated equipment from elsewhere in the hospital stored unsafely with clean equipment and clean baby cots; this presented a risk of cross-infection and harm. These risks had not been recognised by the service.
- This meant that there was a risk that the information used to provide the trust with assurance and oversight may not have been accurate or reliable.

Leadership of service

- Staff told us that both the senior executive team and the nursing team were visible in children's and young people's services. Staff felt that managers were approachable and supportive of staff.
- There was a defined leadership structure in place for both nursing and medical staff. However, nursing staff told us that there had been a significant period of time when there was no matron in post, and this had had an impact on the workload of senior nurses.
- Staff said that they felt supported and could go to both medical staff and nursing staff with concerns.
- There was a new matron for the children's ward following the post being vacant for approximately seven months. Staff told us that they hoped they would be supported in the future and stated that the post being vacant had put pressure on the service. We asked the trust why there had been a delay in recruiting to this post but they were unable to tell us.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Staff told us that they felt respected and a valued part of the team.
- Staff told us that there was a positive culture within teams and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children.
- Children's and young people's experiences and quality of care were central in all decision making.
- Staff were passionate in wanting to drive quality forward in order to continually improve.

Public and staff engagement

- At the time of the inspection, the trust was discussing implementation of a children's patient experience group.
- Young people had previously been consulted in the future design of a teenage room on the children's ward. Staff told us that they valued this input.

Services for children and young people

- Comment cards were available and accessible in all children's and young people's services.
- Parents and children were able to take part in patient surveys that were offered in age-appropriate formats in both inpatient and outpatient areas. Formats included the use of handheld electronic devices.
- Initiatives such as the 'Tops and Pants' satisfaction scale for children and 'Growing Seeds to Acorns' scheme were in place to ensure that patient feedback was used directly to improve the quality of service provided.
- The trust offered open days for people to visit children's services.

Innovation, improvement and sustainability

- Staff had innovative ideas on how to improve services. Staff were passionate about continually improving children's and young people's services.
- Staff in children's and young people's services were forward thinking about how the services could be adapted to provide flexibility and sustainability in the future. They were committed to developing relationships across health networks.
- We found some examples of innovation including a new handover pilot that helped clinical staff to communicate efficiently and a text service using a social media company.

End of life care

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

Information about the service

End of life care was delivered by staff on the hospital wards at Macclesfield District General Hospital (MDGH). There was a Macmillan specialist palliative care team (SPCT) that provided support for patients with cancer and a palliative care consultant who provided advice and support for all other patients with palliative care needs. Face-to-face palliative care services were available weekdays with an out-of-hours phone service.

We visited five wards, the Macmillan cancer centre, the accident and emergency department, the mortuary, the engineer's department (to inspect how equipment was maintained) and the chapel plus the general administration offices from where relatives collected death certificates and received information about bereavement services.

During our inspection we spoke with 46 staff including doctors, nurses, engineers, administrative staff, chaplains and mortuary porters. There were only three patients receiving end of life care in the hospital at the time of the inspection who were able to speak with us. We also had the opportunity to speak with three relatives, one who had recently been bereaved.

Summary of findings

Consultant and specialist palliative care services were available but lacked clear lines of communication between them to provide an effective service. There was a committed SPCT but end of life care services lacked organisational structure and leadership. The palliative care service was limited to weekdays only with only informal consultant cover provided during periods of absence. Staff had not received any training for end of life care in the past six months due to staff shortages. There were variations in completeness of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms across the hospital. Forms were supposed to be reviewed daily but evidence suggested that this did not happen consistently. Action plans had been developed in response to the National Care of the Dying Audit of Hospitals (NCDAH) but their implementation was only partially completed at the time of the inspection. There was evidence of good multidisciplinary team working on the wards and that pain relief was managed effectively. In the main, medicines were managed safely and administered by competent staff. However, some 'when required' (PRN) medicine such as pain relief did not have a maximum dose prescribed that could be administered within a 24-hour period. This meant that patients could potentially receive more than the recommended dose.

Most staff were aware of how to report and respond to incidents and they received feedback to ensure that they learned from incidents. Safeguarding systems were

End of life care

well embedded in the service. In the NCDAH for 2012/13 the trust had performed in line with or better than the England average for 14 of the 17 key performance indicators. The end of life care plan (EOLC plan) introduced in July 2014 had been developed to replace the Liverpool Care Pathway. The plan included guidance for the care team on recognising and responding to deteriorating patients to ensure that their care was timely and managed effectively and that patients' preferred priorities for care were met.

The fast-track system worked well and requests were usually fulfilled within a day. There was evidence to show that most people managed to die in their preferred place of care. Consultants commented on the timely response they received to requests for support from the palliative care consultant. Patients and relatives had confidence in the medical and nursing staff and felt that they had been involved in planning their end of life care. Staff were observed to listen and respond appropriately to patients' requests in a kind and caring manner. Patients and relatives told us that they found the staff to be kind and understanding and they spoke highly of the care and support provided.

Are end of life care services safe?

Good

Most staff were aware of how to report and respond to incidents and they received feedback to ensure that they learned from incidents. Safeguarding systems were well embedded in the service. In the main, medicines were managed safely and administered by competent staff. However, some 'when required' (PRN) medicine such as pain relief did not have a maximum dose prescribed that could be administered within a 24-hour period. This meant that patients could potentially receive more than the recommended dose.

There was evidence of documented good multidisciplinary care for patients in the medical records. Entries of all disciplines were legible, signed, timed and dated and of a good standard to ensure clear and safe communication. The EOLC plan introduced in July 2014 had been developed to replace the Liverpool Care Pathway. The plan included guidance for the care team about recognising and responding to deteriorating patients to ensure that their care was timely and managed effectively and that patients' preferred priorities for care were met.

The trust employed a full-time consultant in palliative medicine; however, there was no formal cover arrangements for periods of absence such as annual leave. The consultant advised us that cover was provided by a colleague based at a local hospice, but these arrangements were not always communicated clearly to the SPCT. Staff also told us that the person supposed to be providing cover was sometimes unaware of the arrangements when contacted.

Incidents

- Staff understood how to report and enter an incident on the trust's electronic incident-reporting system. However, we noted that a 'near miss' had been retrospectively recorded in a patient's medical file but this had not been recorded on the system. This matter was reported to the ward manager at the time of the inspection and was acted upon immediately.
- Staff received feedback from incidents they had reported and were able to explain actions that had been taken to minimise the risk of recurrence.

End of life care

- We saw evidence that reported incidents were routinely discussed at ward meetings to ensure that learning from incidents took place. There was a system that ensured staff unable to attend a meeting read a copy of the minutes and signed to confirm that they had read and understood the information.
- Staff were able to demonstrate how incidents of pressure sores were managed. We saw evidence to show that a pressure ulcer steering group had been established to review these incidents and to identify best practice to minimise the number of incidents occurring; recommendations included ensuring that the appropriate mattresses were used and that they were fit for purpose.

Medicines

- Medicines were stored securely in locked cupboards and fridges in accordance with regulatory requirements.
- Records showed that temperatures were checked daily to ensure that medicines were stored at the optimum temperature in accordance with the manufacturers' recommendations.
- Medicines were administered safely in accordance with the trust's medicines management policy.
- There was guidance for medical staff regarding anticipatory prescribing to ensure effective control of symptoms such as pain relief and nausea.
- Controlled drugs were stored safely and prepared and administered in accordance with the Controlled Drugs Regulations 2013. There were arrangements in place to check that stock levels correlated with the amount recorded in the drug register.
- We saw evidence that staff competency to administer medicines (including intravenous drugs) had been assessed.
- However, some 'when required' (PRN) medicine such as pain relief did not have a maximum dose prescribed that could be administered within a 24-hour period. This meant that patients could potentially receive more than the recommended dose.

Records

- In all the clinical areas we visited records were stored securely.
- There was evidence of documented good multidisciplinary care for patients in the medical records. Entries of all disciplines were legible, signed, timed and dated and of a good standard to ensure clear and safe communication.
- The files were maintained in a secure format to minimise the risk of records becoming separated or misfiled.
- There was evidence to show that staff received training during their induction and ongoing training regarding information governance.
- The mortuary team maintained secure and accurate records of organ donations.

Safeguarding

- Safeguarding awareness and understanding of its importance were well embedded in the service. Nursing and medical staff were able to show us how they could access up-to-date safeguarding guidelines and they were able to discuss safeguarding arrangements in an informed manner.
- Safeguarding contact details were clearly displayed in the wards.
- We reviewed training records and saw that there was good compliance with safeguarding training.
- Information was displayed for visitors to advise them what they should do and who they could contact if they had a safeguarding concern, such as the suspected abuse of a person known to them.
- Nursing and administrative staff were aware of the trust's whistleblowing policy and knew how to raise a concern.

Mandatory training

- The ward and palliative care staff were able to describe the mandatory training they received and to provide evidence of this. Training included health and safety awareness, information governance and hand hygiene.
- Mandatory training included a section entitled 'You Only Die Once' to ensure that there was staff awareness of the needs of the dying patient.
- There were electronic systems in place to monitor and report progress with mandatory training to ensure that a high level of compliance was maintained.

Assessing and responding to patient risk

- Staff were familiar with people's wishes as detailed in their EOLC plans and advanced decisions plans.

End of life care

- The EOLC plan, introduced in July 2014, had been developed to replace the Liverpool Care Pathway. The plan included guidance for the care team about recognising and responding to deteriorating patients to ensure that their care was timely and managed effectively and that patients' preferred priorities for care were met.
- The EOLC plan contained information for staff about where they could obtain further advice and guidance about appropriate care if required.
- Staff were able to describe the process they would use if the resuscitation team was required.

Nursing staffing

- There was a Macmillan SPCT to provide support to patients with cancer. The team comprised five full-time nurses, including a lead palliative care nurse, and provided a service to the local community and the hospital. Staff told us that they served a community of approximately 40,000 people in addition to providing support to patients in the hospital. They had 30 active patients at the time of our inspection (i.e. those patients currently requiring end of life care).
- Ward staff felt very well supported by the SPCT and could access their advice and support readily when required.
- We observed that formal handovers took place between staff on the wards at the beginning of shifts.
- Staff told us that they were sometimes unable to complete their two-hourly rounds due to low staffing levels and high dependency of the patients, which meant they were unable to identify and respond in a timely manner to people's individual needs.

Medical staffing

- The trust employed a full-time consultant in palliative medicine; however, there was no formal cover arrangements for periods of absence such as annual leave. The consultant advised us that cover was provided by a colleague based at a local hospice but these arrangements were not always communicated clearly to the SPCT. Staff also told us that the person supposed to be providing cover was sometimes unaware of the arrangements when contacted.

Major incident awareness and training

- The chaplaincy team was aware of the major incident plans and had been involved in scenario training.

Are end of life care services effective?

Requires Improvement

Consultant and specialist palliative care services were available but lacked clear lines of communication between them to provide an effective service. For example, the SPCT was not always made aware of the consultant cover arrangements in place during periods of annual leave or absence or out of hours. The palliative care service was limited to weekdays only with only informal consultant cover provided during periods of absence. Staff explained that they had not received any training for end of life care in the past six months. Training sessions were prepared and offered to staff by the SPCT but, due to staff shortages, staff had been unable to attend.

There were variations in completeness of DNA CPR forms across the hospital. Forms were supposed to be reviewed daily but evidence suggested that this did not happen consistently. In the NCDAH for 2012/13, the trust had performed in line with or better than the England average for 14 of the 17 key performance indicators. Action plans had been developed in response to the National Care of the Dying Audit of Hospitals (NCDAH) , including the development of the EOLC plan, but their implementation was only partially completed at the time of the inspection. There was evidence of good multidisciplinary team working on the wards and that pain relief was managed effectively.

Evidence-based care and treatment

- Implementation and awareness of National Institute for Health and Care Excellence (NICE) guidance was led by the palliative care consultant. Staff explained that they received emails advising them of new guidance relating to their clinical practice.
- Care plans for some patients receiving end of life care were incomplete and they lacked evidence that care had been tailored to meet the patient's individual needs. A new EOLC plan had been developed and introduced recently.
- The hospital participated in the NCDAH. Following the NCDAH results, the trust had developed an action plan that included the development of a new EOLC plan. This was distinctively coloured to allow staff to recognise to easily and to access the plan; however, this had not been fully introduced in all clinical areas.

End of life care

- Staff felt that the new care plan was helpful in that it addressed all aspects of the patient's care and acted as a helpful prompt.
- The junior doctors explained that they were familiar with the new EOLC plan but its use was always commenced by the registrar to ensure that the patient's initial assessment was undertaken by a suitably experienced doctor.
- The renal team used a withdrawal of dialysis pathway when required. The pathway included clear guidance about arrangements required from the multidisciplinary team (MDT) to ensure that the patient's wishes and preferred place of death were met in a safe and cohesive manner. To support this there was also a patient leaflet available entitled 'What happens if I stop dialysis?' to help patients make informed decisions.

Pain relief

- Pain relief was provided promptly and staff checked to assess if it had been effective.
- We observed staff discussing the patient's degree of pain with them and the options for treatment available before administering analgesia.
- 'When required' (PRN) medicine was prescribed to manage any breakthrough pain. This is pain that occurs in between regular scheduled pain relief.
- The trust surveyed bereaved relatives during 2013 and found that 88% (trustwide) felt the doctors and nurses did enough to help relieve the patient's pain.
- Anticipatory prescribing was common, in line with best practice, so that pain relief and other medication could be started quickly if a patient became unwell.

Equipment

- Staff reported that there was an adequate supply of syringe drivers for use when providing pain control but that these were sometimes difficult to locate within the hospital as the hospital did not have a central store.
- We saw that there were effective systems for the preventative planned maintenance of equipment.

Facilities

- The hospital did not have facilities for relatives such as a room for overnight stays or for informal meetings in the main ward areas. To partially overcome this, recliner chairs and blankets were provided at the patient's bedside for overnight stays.
- The mortuary viewing room was well maintained and there was a hospital chapel that was easily accessible and central to the hospital.

Hydration and nutrition

- In the NCDAH for 2013/14 the trust had performed in line with or better than the England average for the clinical key performance indicators for ensuring that reviews of patients' nutrition and hydration were completed effectively.
- However, there was evidence that patients' hydration needs had been discussed with only 28% of patients' relatives and only 6% of patients. Similarly, 15 patients assessed as clinically capable of being involved in decisions about meeting their nutritional needs had not been involved. This meant that patients' wishes were not always taken into account when planning care.
- Dietary plans were in place and showed that a dietician was involved and ideas about preferences sought from next of kin. Soft diets were provided where appropriate. However, records showed a lack of evidence that patients had been involved when the dietician reviewed the dietary plan.
- The new EOLC plan included in the assessment section 'Risks and benefits of nutrition and hydration'. In the management plan section (which was completed by the doctor), there were guidance notes specific to nutrition and hydration. These stated in bold text: "Food and drink should be continued for as long as the person can tolerate/desires this." The guidance gave prompts such as a swallowing assessment if this was thought to be beneficial. It also stated that clinically assisted nutrition and hydration must be in line with the General Medical Council's 2010 guidance on 'Treatment and care towards the end of life'.

Patient outcomes

- In the NCDAH for 2012/13, the trust had performed in line with or better than the England average for 14 of the 17 key performance indicators.
- The trust had performed worse than the England average for three of the 10 clinical key performance indicators. As a result, the trust had created an action plan that included the roll-out of a new EOLC plan.
- For example, the trust had performed worse than the England average for 'PRN medication prescribed for the five key symptoms that may occur during the dying phase'. Actions to improve this area included staff

education on the drugs used to treat the five symptoms and an update of the palliative care symptom control guidelines. However, the target dates for completion of these actions was March 2015 and February 2015 respectively, so they had not been fully implemented at the time of our inspection.
- An audit of telephone call requests made to the SPCT undertaken by the palliative care consultant estimated that 17 hospital admissions had been prevented as a result of telephone discussions.
- Some 94% of referrals to the service were for patients with cancer. A referral form was completed to access the Macmillan SPCT with clear needs-based referral criteria. Referrals to the palliative consultant were done directly and noted in patients' records. No specific audit had been undertaken to assess referral response times; we were told that a response was usually received within three days.

Competent staff

- Staff explained that they had not received any training for end of life care in the past six months. Training sessions were prepared and offered to staff by the SPCT but, due to staff shortages, staff had been unable to attend.
- Portering staff looking after the mortuary service received bi-annual training including on topics such as patient confidentiality, privacy and dignity.
- One of the mortuary staff had requested to attend a bereavement course and had been supported to do this.
- The palliative care consultant provided 15 training sessions a year, including eight sessions to junior doctors on symptom control and end of life care.
- Staff received annual appraisals. Clinical supervision was available to staff on request.
- Staff in the general office had responsibility for meeting bereaved relatives and providing death certificates. While they had learned their duties from colleagues, they had not received any formal training and felt that this would have been beneficial.
- Medical and nursing staff participated in simulation training days. A recent event had been based on an acute medical patient living with dementia and requiring end of life care.

Multidisciplinary working

- We observed the MDT reviewing each patient's care to ensure that their changing needs were responded to in a timely manner. Staff explained that the MDT reviews were completed every morning.
- There was evidence of good MDT working to provide effective end of life care within some specialties. For example, the renal team was able to describe how it involved all relevant disciplines, including the nephrologist, nurses, GPs and SPCT. There was clear evidence of this in patients' medical records.
- From discussions with the consultant and the SPCT, it appeared that the two often worked in isolation, and in some instances this led to a breakdown in communication. For example, the SPCT was not always made aware of the consultant cover arrangements in place during periods of annual leave or absence or out of hours.
- There was evidence of good joint working with community services and the district nursing service.

Seven-day services

- The SPCT was available from Monday to Friday.
- The SPCT advised us that a bid had been placed for two full-time posts in order to provide a full seven-day service in accordance with best practice. This was corroborated by the service line manager.
- Ward staff explained that out of hours they sought advice from the local hospice or another hospital based in Manchester.

Access to information

- The staff had access to information relating to end of life care on the intranet; this contained useful contact details, a resource library, learning and education events, competency assessment tools and guidance.
- Ward staff had access to a palliative care consultant and Macmillan pharmacist for specialist advice.
- There were various information documents available for relatives, such as 'What to do after death'.
- Information documents were managed effectively to ensure that they were up to date and easily accessible to the general public.
- The SPCT used an electronic records system that was also used by the district nurses and GPs in the community. At the time of inspection, the hospices within the trust did not use this system. The staff explained that because of this, they wrote in the

medical records and on the electronic records. This meant that there was duplication of effort and a potential risk of miscommunication about patients' care and treatment.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We looked at four advanced care plans and three DNA CPR forms. There were variations in completeness of the forms across the hospital. For example, the reason for the DNA CPR decision on one form had not been completed; however, there were clear notes in the medical record entered by the consultant regarding the decision.
- DNA CPR forms were supposed to be reviewed daily but there was no evidence to show that this happened. We looked at three DNA CPR forms in use at the time of the inspection: two were incomplete and one had not been reviewed for a week.
- In the outpatients vascular clinic we found that a DNA CPR decision had been made due to the patient's medical condition and lack of capacity. This had been put in place for 24 hours as the staff had been unable to contact the patient's spouse. This was documented on 4 November 2014 and there was no evidence of a review, mental capacity assessment, best interest meeting, or other discussion with professionals to ensure that this person received care in line with the Mental Capacity Act.
- The resuscitation officer completed a hospital-wide audit of DNA CPR forms to evaluate whether they were being used correctly, although we did not see evidence of this during the inspection. Nursing staff told us that findings were fed back to relevant departments for action.
- Deprivation of liberty safeguards (DoLS) applications were discussed with nursing staff. The senior nurse on ward 9 demonstrated a good understanding of DoLS and was able describe situations when an application may be required and explained that one staff member on the ward had received formal DoLS training.
- Nurses had access to relevant guidance about DoLS, including flow charts for quick reference.

Are end of life care services caring?

Good

Patients and relatives had confidence in the medical and nursing staff and felt that they had been involved in planning their end of life care. Staff were observed to listen and respond appropriately to patients' requests in a kind and caring manner.

Patients and relatives told us that they found the staff to be kind and understanding and spoke highly of the care and support provided.

Compassionate care

- Patients told us that they felt they were cared for with kindness and compassion and that staff ensured that their dignity was maintained. For example, nurses ensured that curtains were drawn before providing personal care and spoke quietly with patients to ensure privacy and confidentiality.
- Portering staff working in the mortuary had a good understanding of their responsibilities to ensure that people's privacy and dignity were respected.
- We spoke with a recently bereaved relative who said: "I couldn't fault them; they did everything they could to make my wife comfortable. I was able to visit and stay as long as I wished. The doctor talked with me and explained she would not pull through. We talked about her care and our wishes were respected."
- A patient told us: "It's the smiles that count; the staff go above and beyond what I would expect of them."
- A local survey of bereaved relatives was undertaken by the hospital. A large majority had confidence in the staff and agreed that doctors and nurses made time to discuss their relative's or friend's condition. They considered they had been adequately prepared for the fact that their relative or friend was likely to die soon and were given enough help and support at the time of death.

Understanding and involvement of patients and those close to them

- Patients told us that they felt their requests and opinions about the management of their care were listened to and respected.

End of life care

- A patient told us that they wanted to die at home and had been involved in the discussions about how this could be arranged.
- Patients who were identified as approaching the end of life were offered the opportunity to create an advanced care plan, including end of life care wishes and any advanced directives.
- The NCDAH 2012/13 results showed that the trust performed slightly better than the England average for the percentage of 'health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying'.
- We saw evidence where there had been a joint review between the SPCT and medical staff regarding the extent of the patient's disease. Records contained a good account of the discussion with the patient and noted whether they wished for more time to decide if the patient or the care team told their relative about their diagnosis. However, the records did not contain information about how the patient responded to being told of the progression of their disease so that staff were able to provide appropriate emotional support.

Emotional support

- The hospital had an adequately staffed and accessible chaplaincy team in accordance with national recommendations. The team was also supported by volunteer visitors.
- The chapel was open all day and provided suitable facilities for different faiths and for religious and spiritual beliefs. Access to the chapel during the night could be arranged via the night sisters.
- However, the chaplaincy team reported that their services were often requested too late for them to meet patients' and relatives' religious or spiritual needs. This problem was further evidenced by feedback from a survey of relatives undertaken by East Cheshire bereavement service.
- The hospital did not provide a bereavement service but provided a leaflet that directed relatives to external bereavement services.
- The NCDAH 2012/13 results showed that the trust performed worse than the England average for its assessment of the spiritual needs of the patient and of their nominated relatives or friends.
- There was evidence, such as patient feedback, that renal patients felt that they received good support from the care team; this was even available between hospital visits, via telephone calls.
- There was a counselling service available to cancer patients and relatives provided by trained volunteer staff via the Macmillan cancer support team.

Are end of life care services responsive?

Good

The fast-track system worked well and requests were usually fulfilled within a day. There was evidence to show that most people managed to die in their preferred place of care. There were prompts in the EOLC plan assessment to encourage staff to consider additional communication needs such as hearing impairment or speech difficulties. We saw evidence of the creation of a dementia-friendly room for people living with dementia, although it had not been completed at the time of the inspection. These rooms often contain a patient's personal items for them to relate to and to help them remain oriented.

Consultants commented on the timely response they received to requests for support from the palliative care consultant. The consultant's and SPCT's secretarial support had been reduced, which meant that the SPCT felt it was less responsive in the service it provided. For example, there were delays in responding to urgent calls from patients or their relatives as there was no secretary to receive telephone calls. Staff were unable to tell us what action they had taken to try to address this issue and to minimise any risk.

Service planning and delivery to meet the needs of local people

- Nursing staff reported that a high number of patients were supported to die at home as their preferred location and there was evidence to show that the number of in-hospital deaths was very low compared with all other trusts in England.
- The most recent NCDAH (2013/14) for the trust revealed that, where a patient's preferred place of dying was somewhere other than in hospital, 75% had

documentation of discussions and activities to initiate discharge planning in the last episode of care. This meant that there were appropriate arrangements in place to ensure that patients' wishes were respected.
- There was a fast-track or rapid discharge system in place. The fast-track service aimed to ensure that patients could be discharged to their preferred place of care by making sure there was adequate support in place to provide safe and effective end of life care.
- The administrative staff in the general office checked every day to ascertain if death certificates were ready for relatives to collect and ensured that they phoned them if they were not ready for collection to prevent the distress of a wasted journey.

Meeting people's individual needs

- Open visiting was available to relatives.
- There was access to interpretation services if required.
- There were prompts in the EOLC plan assessment such as: 'Communication difficulties to consider – Deafness, speech difficulties. Is there a patient passport or interpreter required?'
- We saw evidence of the creation of a dementia-friendly room for people living with dementia, although it had not been completed at the time of the inspection. These rooms often contain a patient's personal items for them to relate to and to help them remain oriented.
- Staff received training on dementia awareness. Approximately 40% of staff had completed this but there was no evidence to show medical staff had participated.
- One patient we spoke with on ward 4 was very complimentary about the care received but would have liked to have had access to bedside radio and television services.

Access and flow

- Consultants commented on the timely response they received to requests for support from the palliative care consultant.
- There were single side rooms available on the wards but staff explained that these were usually given to patients with infections who had to be isolated and took priority.
- Staff told us that the electronic fast-track system for rapid discharge was very slow and usually took 45 minutes to complete. However, staff explained that, although three days were usually allowed to ensure that all relevant equipment was in place, this was usually achieved within a day.
- The consultant's and SPCT's secretarial support had been reduced and the SPCT reported that it were now less responsive in the service it provided. For example, they told us there were delays in responding to urgent calls from patients or their relatives as there was often no one to receive the phone calls. This meant that distressed patients or relatives had to leave a message on an answerphone. At the time of the inspection, staff were unable to show evidence of any measures taken to minimise the impact of the change to ensure that people could access a member of the team quickly.

Learning from complaints and concerns

- A system had been introduced that ensured that the head of the end of life care partnership group was automatically notified of any complaints about the service. This enabled them to ensure that all services involved learned from incidents. For example, a patient with multiple complex needs had made a complaint about their end of life care. An investigation was completed involving all services related to the patient's complaint to help improve communication between services in order to provide effective and responsive care, and to ensure that future incidents were prevented.

Are end of life care services well-led?

Requires Improvement

There was a head of end of life care service development to lead a recently formed organisation-wide partnership but the partnership's effectiveness had still to be evaluated. There was a committed SPCT but end of life care services lacked organisational structure and leadership. From discussions with the palliative care consultant and the SPCT, it was apparent that the overall service was fragmented and the two worked independently.

Audit and outcome data was used to improve care. A trust board member had recently been appointed to represent end of life care services at board level. There was a committed SPCT for cancer patients that also provided support to other patients receiving end of life care when requested. Staff spoke positively about the service the they provided for patients. They felt that the introduction of the new EOLC plan was a positive move to provide a more cohesive service.

End of life care

Vision and strategy for this service

- A partnership had been developed linking key services including East Cheshire (which includes MDGH) and Mid Cheshire trusts, hospices, care commissioning groups and local authorities to ensure that regional and national priorities relating to end of life care were aligned and driven forward. A specific strategy for the provision and development of end of life care was not available.

Governance, risk management and quality measurement

- Using audit and outcome measures, the partnership had identified that poor documentation was having an impact on the quality of the service and as a consequence it had developed an EOLC plan that addressed all aspects of care to meet the needs of the dying patient. The plan was introduced in July 2014 and there were arrangements to evaluate the effectiveness of the care plan in January 2015.

Leadership of service

- In the most recent NCDAH (2013/14), trust board representation and planning for care of the dying achieved a low score because there was no named trust board member representing end of life care. This had recently been addressed and a representative for end of life care had been appointed.
- From discussions with the palliative care consultant and the SPCT, it became apparent that the overall service was fragmented and the two worked independently.
- The Macmillan specialist palliative care nursing service and information for patients had been designed only for the support and care of patients with cancer, although they did provide support to ward staff for non-cancer patients if required.

Culture within the service

- Staff spoke positively about the service they provided for patients. They felt that the introduction of the new EOLC plan was a positive move to provide a more cohesive service.
- We received a mixed response from nursing staff about who was responsible for the leadership of end of life care and palliative care services.
- On the wards we visited, we saw that the team worked well together and recognised the value of good communication between all disciplines.
- The medical staff told us that the SPCT and consultant were responsive to requests for support and advice and worked effectively with the ward teams.

Public and staff engagement

- We saw that there were a number of thank you letters from relatives for the support and kindness they had received at the hospital.
- From comments in cards, letters and survey responses, we saw that people were satisfied with the end of life care their relatives received at the hospital.
- Staff felt that they would benefit from further training about coping with bereaved relatives and providing end of life care. Although training sessions were planned, they were poorly attended due to staffing demands on the wards and in departments.

Innovation, improvement and sustainability

- The accident and emergency department had introduced a system of placing butterflies on cubicle screens to indicate to all staff that a patient had died. This meant that all staff, including those visiting the department such as ambulance staff, were aware of the need to behave quietly and sensitively when in the immediate vicinity.

Outpatients and diagnostic imaging

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

Information about the service

East Cheshire NHS Trust provides outpatient services in Macclesfield District General Hospital (MDGH, the main site) and in community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton.

The outpatients department is open from 8.30am to 5pm, Monday to Friday. However, extra clinics are also scheduled in the evening and at the weekend.

The radiology department is based at MDGH and provides a range of diagnostic imaging services, including: general radiology, fluoroscopy, dental, ultrasound, CT scanning, MRI scanning, orthopaedic x-ray, obstetric ultrasound and the Victoria breast unit. There are three peripheral sites located at Knutsford Hospital, Congleton War Memorial Hospital and Handforth Health Clinic along with a mobile unit that covers the Stockport area for screening.

We visited the outpatient and radiology department at MDGH on 10, 11 and 12 December 2014. During our inspection we attended a variety of clinics, including: fracture clinic, ear, nose and throat (ENT), orthopaedic, ophthalmology, phlebotomy, dermatology, x-ray, neurology and cardiology. We spoke to a range of staff including healthcare assistants, nurses, doctors, clinical nurse specialists, receptionists and administrative staff in the coding and records departments. We also spoke with a number of people who used the outpatients and diagnostic imaging department at MDGH.

Summary of findings

Incidents were not always reported in line with trust policy, which meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in the outpatients and diagnostic imaging services. Records in the outpatients department and the occupational therapy, physiotherapy and orthotics departments were not stored securely, which meant that there was a risk of people's records and personal details being seen or removed by people in the department. Records were not always available in time for clinics and on occasion this led to the cancellation of clinics.

The organisation of the outpatients departments was not always responsive to patients' needs. The trust recognised that the layout and size of the department was insufficient to provide a safe environment for the number of people using the unit. However, there were no action plans or procedures that had been put in place to mitigate risk or to change the environment. Equipment had not been maintained in line with manufacturers' recommendations. Nearly a third of clinics were cancelled and patients experienced delays when waiting for their appointments. The vision and strategy for outpatients and diagnostic imaging services were not clear. Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and those identified were not being managed effectively.

Outpatients and diagnostic imaging

Cancer waiting times were consistently better than the England average for the 31-day and 62-day targets. Since September 2013, referral-to-treatment times (RTT) for patients with incomplete pathways had been better than the England average. RTT for non-admitted patients had been inconsistent between April 2013 and May 2014 but were better than the England average from June 2014. Diagnostic waiting times had been better than the England average since November 2013.

There was evidence of good multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. We found that staff were approachable, welcoming and friendly. Staff were discreet and kind when they saw that a person was upset, and we saw them take extra time to communicate with people if they deemed it necessary.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Incidents were not always reported in line with trust policy. For example, records were sometimes not available for clinics and concerns were raised with us regarding the weight loss of patients waiting to access speech and language therapy services. Neither of these issues had been reported via the electronic reporting system. This meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in outpatients and diagnostic imaging services.

The radiology department used patient group direction (PGD) policies to allow staff who were not trained to prescribe medication to give one or two specific medications for certain procedures. We looked at these policies and saw that, although the candidates had signed to agree with the procedure and instructions in the PGD, there was no authorising signature on any of these documents. This meant that the documents were invalid and therefore staff were administering these medications without authorisation.

Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively. The trust recognised that the layout and size of the department was insufficient to provide a safe environment for the number of people using the unit. However, there were no action plans or procedures that had been put in place to mitigate risk or to change the environment. Equipment had not been maintained in line with manufacturers' recommendations. For example, we found a plaster saw in the plastering room that was last serviced in 2012.

Records in the outpatients department were stored in trolleys that were not secure; we found that the number of records in the department was so large they were being stored in clinic rooms and also on the floor. In the occupational therapy, physiotherapy and orthotics department we saw that a clinic room was unlocked and patient notes were kept in unlocked filing cabinets. This meant that there was a risk of people's records and personal details being seen or removed by people in the department.

Outpatients and diagnostic imaging

Incidents

- Data provided by the trust showed that there had been two incidents reported by the outpatients department in the last year. Both incidents were categorised as 'low harm'.
- Staff were familiar with the electronic reporting system to report incidents within the department. However, we spoke to healthcare assistants in the outpatients department and one of them told us that they did not routinely have access to a computer to report incidents via the electronic reporting system. Another healthcare assistant told us that not all staff had 'log on' details to use the system. In these cases, staff reported concerns to a member of the nursing staff.
- We spoke to a radiographer, two sisters and a staff nurse about the electronic incident-reporting system and were told that there was no formal training on how to use the system. As a result, it was clear that staff had different opinions on which incidents should be reported. One person told us: "Any incident or near miss should be reported on [the system]." Another staff member said: "Some people report small things on [the system] which is a waste of time."
- We found that incidents were not always being reported in line with trust policy. For example, records were sometimes not available for clinics and concerns were raised with us regarding the weight loss of patients waiting to access speech and language therapy services. Neither of these issues had been reported via the electronic reporting system. This meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in outpatients and diagnostic imaging services.

Cleanliness, infection control and hygiene

- We looked at all areas of the outpatients department at MDGH, and other parts of the outpatients and diagnostic imaging services in MDGH, including: the clinical and office areas in the radiology department, orthopaedic clinics, the plaster room, service user waiting areas and facilities, along with clerical areas and records storage areas.
- All of these areas were clean and tidy, although in the radiology department there were public toilets that had no cleaning schedules, and the cleaning policies displayed were dated from 2007.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and infection control guidelines were clearly displayed in the outpatients department. Senior staff were also wearing a pin badge to promote hand hygiene and to remind others to wash their hands.
- Service users and visitors attending the outpatients department were greeted with a large sign reminding them to wash their hands before they entered. The equipment at this station was modern and well stocked, and enabled people to wash their hands without touching the taps, towel dispensers or bins, which ensured a minimal risk of cross-contamination.

Environment and equipment

- In the outpatients department, the resuscitation trolley was stored behind a fire door in a clinic room. These fire doors were held open by a chair and a wooden wedge. This meant that the resuscitation trolley would have been difficult to access in an emergency, and, in the event of a fire, the room would not be protected by the fire doors as intended.
- The outpatients department had two reception desks, which caused confusion among people visiting the clinics about which one to book into. In the afternoon we saw that one desk had closed, and this meant that people were sitting in the waiting room with no supervision. We saw that the printer on this desk had confidential information in its out tray, and when we spoke to senior staff about this they removed it and told us that the printer had recently been fixed and had printed the remainder of a print queue unexpectedly.
- Radiographers showed us the procedure for eliminating exposure to radiation and the personal protective equipment in place for staff to use. We were told that patients were asked a series of questions, for example to check if they may be pregnant, to reduce the risk of exposure. We saw signs in the changing area that reminded patients to inform staff of key information.
- The fracture clinic reception area was very busy during our inspection, and although a red line was on the floor to encourage people to stand back while the receptionist was talking to people it was possible for other patients and visitors to hear the conversations between patients and staff.

Outpatients and diagnostic imaging

- There was a high volume of patients and medical staff in the fracture clinic and we observed medical staff sharing clinical rooms due to a lack of available consulting rooms for the clinic. This meant that patient privacy could be compromised.
- The outpatients department had an unlocked clinic or store room. Although most cupboards and fridges were locked, there were sharp cannulas and equipment stored in there that could cause injury to a member of the public if they were to enter the room. Due to the layout of the department, this room could not be monitored closely, and there was a constant flow of people walking past it.
- We found that a plaster saw in the plastering room had a sticker on it showing that it had been checked in 2009; records suggested that it was last serviced in 2012. We informed the trust about this during the inspection and it arranged for the equipment department to check and re-label the saw.
- Some equipment in the hand therapy clinic was overdue a service. An electronic plinth had a label dated November 2012, and the water bath and therapy bath were due to be checked in January 2014. This meant that equipment had not been checked in line with the manufacturers' recommendations.

Medicines

- Medications in the outpatients department were stored inside a locked cupboard or fridge.
- In radiology we saw that medications were managed safely, and we witnessed staff double-checking the expiry date and content of a flush injection before it was administered. This showed that safe handling of medications procedures were being followed.
- The radiology department used PGD policies to allow staff who were not trained to prescribe medication to give one or two specific medications for certain procedures. We looked at these policies and saw that, although the candidates had signed to agree with the procedure and instructions in the PGD, there was no authorising signature on any of these documents. This meant that the documents were invalid and therefore staff were administering these medications without authorisation. This is contrary to the guidance provided by the Medicines and Healthcare Products Regulatory Agency (MHRA), which regulates medicines and medical devices, and by the National Institute for Health and Care Excellence (NICE).

Records

- Records in the outpatients department were stored in trolleys that were located behind the reception desk. These were not secure and later in the inspection the number of records in the department was so large that they were being stored in clinic rooms and also on the floor.
- At times we observed up to 10 trollies of records in the department; their storage created an obstruction to the area behind the reception desk, causing a risk to staff moving in the area.
- In the occupational therapy, physiotherapy and orthotics department we saw that a clinic room was unlocked and patient notes were kept in unlocked filing cabinets. This meant that there was a risk of people's records and personal details being seen or removed by people in the department.
- In the ENT clinic, ophthalmology clinic and occasionally in the fracture clinic, we were told that records were not always available. This meant that medical staff did not have access to the most current information regarding patients' care and treatment.

Safeguarding

- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- The senior nurse in the outpatients department described a safeguarding incident a member of staff dealt with and the procedure that was followed.
- Training records in the outpatients department showed that all staff had completed adult and children's safeguarding training, and we saw that bank staff employed in outpatients were trained to level three standards. This meant that staff employed to work in the outpatients department were trained and knowledgeable in the procedures for safeguarding adults and children from abuse.

Mandatory training

- We looked at the training records for staff working in the outpatients department and saw that there was 100% compliance with mandatory training.

Assessing and responding to patient risk

- Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively.

Outpatients and diagnostic imaging

- The online risk assessment for the radiology department showed the hazards present in the department, the level of risk presented, and the control measures and practices in place to reduce the risks. The risk assessments were due to be reviewed again according to the trust's policy, which stipulated that risk assessments were to be reviewed every six months, but this had not taken place at the time of our inspection.
- The manager of the outpatients department told us that the trust recognised that the layout and size of the department were insufficient to provide a safe environment for the number of people using the unit. However, despite this issue being identified we were not shown any evidence of action plans or procedures that had been put in place to mitigate risk or to change the environment.
- In the orthopaedic outpatients clinic we were told about an incident where a person tripped on the mat at the entrance. We were told that this had been reviewed and the mat had been replaced following a risk assessment; however, we did not see any written evidence of this.
- We spoke to senior speech and language therapist who raised concerns about the length of time it was taking for some patients to be reviewed by the department. They told us that they were concerned about the level of weight loss service users were experiencing before being reviewed. We asked if this had been reported or escalated and we were told that it had not been.

Nursing staffing

- Staff felt that the nursing numbers and skill mix met the needs of patients.
- One administration manager told us that, on occasion, extra clinics were required to meet the needs of the local area. We were told that the service was usually able to cover them with their own staff. A display board identified the radiographers working in the department on that day. Services were staffed according to this board. Three radiographers told us that they were working overtime hours to cover the service. They told us that there were plans to increase the service to cover evenings, nights and weekends. One radiographer felt that this would not be possible with the current level of staffing the department had.

Medical staffing

- During our inspection we spoke to two doctors running clinics in the outpatients department. One doctor was a locum doctor, employed temporarily due to a shortage of permanent staff. This doctor explained that he had worked regularly at the clinic providing continuity of care to people using the services. There was a shortage of orthopaedic consultants that meant the consultants were working extended hours to cover the service. Staff told us that response times were becoming slower due to staffing shortages.

Are outpatient and diagnostic imaging services effective?

Records were not always available in time for clinics. We spoke to staff running the clinics in the outpatients department and they told us that on occasion appointments had to be cancelled or delayed if the records were not available.

Staff were trained in core subjects such as infection control, safeguarding and health and safety. Training records in the outpatients department showed that all staff were up to date with mandatory training.

There was evidence of good multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at the weekends to meet the needs of the local population. The radiography department had an on-call system to cover out-of-hours scans required for inpatients of the hospital. We were told that there were plans to staff the radiography department 24 hours a day, but these had not been implemented at the time of the inspection.

Evidence-based care and treatment

- We looked at the radiography department's policy on consent. Radiographers told us how they followed the policy to ensure that consent was gained for each scan or procedure, and one radiographer told us that they had raised some documentation issues with their manager and were trying to make documentation of consent clearer.
- We compared the practice we saw with the Society and College of Radiographers' recommendations and saw that the department's practice was in line with professional guidance.

Outpatients and diagnostic imaging

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic settings.
- Prescribed pain relief was monitored for efficacy and changed to meet patients' needs where appropriate.

Patient outcomes

- We were told by the surgical nurse specialist and a radiographer about collaborative working with local universities and hospitals to share innovation and improve the service. We did not see an action plan or documented evidence of this from the trust.
- The therapies department worked with Keele University and conducted joint research projects with them to improve the performance of the department.

Competent staff

- Staff were trained in core subjects such as infection control, safeguarding and health and safety.
- Training records in the outpatients department showed that all staff were up to date with mandatory training.
- Staff in the outpatients department told us that they had yearly appraisals. The sister in charge of the outpatients department told us that supervisions were not routinely carried out, but there was an 'open door' policy and staff could request supervision at any time if they wanted to.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatients and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment.
- Two sisters in the outpatients department told us that they had monthly meetings with their line manager, and then held meetings with their staff to cascade any information. There was little evidence of information going further up the management chain than the managers of the units, and staff told us that they "did not hear or see any managers other than unit managers".

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, extra clinics were also scheduled in the evening and at weekends to meet the needs of the local population.
- X-ray services were available at the Congleton War Memorial Hospital from 9am to 5pm, Monday to Friday only. If patients attended after 5pm they had to wait until the next day; if patients presented at the weekend they had to wait until Monday morning or, in urgent cases, go to MDGH.
- The x-ray department at MDGH was open 24 hours a day, seven days a week. There was limited access to specialist investigations such as MRI and CT scans or to a radiologist to interpret scans out of hours. The department had an on-call system to cover out-of-hours scans required for inpatients of the hospital. We were told that there were plans to staff the radiography department 24 hours a day, but this had not been implemented at the time of the inspection.

Access to information

- We spoke to the manager of the records department about the process of sending notes to the outpatients department to ensure that doctors had the correct information available. We were told that, due to a shortage in staff, sometimes records were not available.
- Reception staff told us that 53 people were due to attend two clinics on Thursday morning during the inspection. They told us that 22 sets of notes were not available at the beginning of the clinic, 16 were found or duplicates made at short notice, and six remained outstanding.
- We spoke to staff running the clinics in the outpatients department and they told us that on occasion appointments had to be cancelled or delayed if the records were not available.
- Systems in the radiography department for requesting scans were electronic and therefore they were not affected by a lack of paper records.
- We spoke to a clerk who told us about the challenges in their department. We were told that 22,000 new records had been put together over the last 12 months, making the workload and storage issues a pressure for staff.
- We were told by the manager of the outpatients and diagnostic imaging services that there was a long-term plan in place to computerise records in order to eradicate these issues.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff received training on the Mental Capacity Act and were confident about seeking consent from patients. Staff were able to explain benefits and risks in a way that patients understood.
- A radiographer told us that they had raised a concern about adequately recording the consent gained from people who used the service. We saw the trust's policy for consent in the radiology department and this reflected guidance from the Royal College of Radiologists.
- We reviewed patient records and in one set of records in the ophthalmology clinic we saw that consent for the procedure was incomplete and dates and signatures were illegible. In a second set of notes we saw that treatment plans were unclear and we were unable to establish what treatment was carried out on the documented visit.

Are outpatient and diagnostic imaging services caring?

Good

We found that staff were approachable, welcoming and friendly. Staff were discreet and kind when they saw that a person was upset, and we saw them take extra time to communicate with people if they deemed it necessary.

People we spoke to told us that the staff are "kind" and the outpatients survey results contained positive comments about the caring ability of the staff in outpatients and diagnostic imaging services.

Compassionate care

- We observed receptionists in the outpatients department speaking to patients in a polite way.
- We saw a healthcare assistant comfort a person who was distressed and arranged for them to have access to a quiet room away from other people in the waiting area. The healthcare assistant then arranged for a member of staff from the ward the person was from to stay with them while they were in the clinic.
- We spoke to a clerk in the booking department of the radiography department who told us that they made calls to people who had been booked for urgent scans through the accident and emergency (A&E) department for the following day. They told us that these patients were likely to be worried and could forget instructions given to them in A&E, so a call to explain things to them helped them remember the process and relaxed them before their visit.
- People we spoke to told us that the staff were "kind" and the outpatients survey contained positive comments about the caring ability of the staff in outpatients and diagnostic imaging services.
- We spoke to a family member in the fracture clinic who told us that the care their relative had received was very efficient and was provided by friendly staff. They had visited the clinic on more than one occasion and were "very impressed" with the service.
- The summary report of the outpatients Patient Experience Questionnaire for 2014/15 showed that the results were better than the national average, and in general they had improved since the previous survey. This summary did not contain information on the number of questionnaires the outpatients department had received, so we were unable to determine the response rate in comparison to the throughput of the department. The report included positive comments such as "the staff and doctors are really friendly and very professional", "the doctor listened to all my symptoms" and "I didn't feel rushed".

Understanding and involvement of patients and those close to them

- The outpatients department had service user questionnaires available to ask people what they thought of the service.
- The trust's outpatients patient experience survey results for quarter 2 (July to September) 2014/15 showed that 95% of patients felt that they were 'definitely' involved in decisions about their care and treatment.
- Staff explained procedures to people and gave them time to understand the procedure and to make them comfortable.
- There was a secure suggestions box in the department in which people could post comments. On the outside of this box, the procedure for complaints and contact details for the Patient Advice and Liaison Service (PALS) were available.

Emotional support

Outpatients and diagnostic imaging

- We spoke to a locum doctor in the outpatients department who told us he thought the service could be improved with a cancer specialist nurse to speak to people who had been given a diagnosis of cancer. We spoke to the manager of the Macmillan unit following this comment, and they confirmed that people from the outpatients department could be referred directly to them.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The organisation of the outpatients department was not always responsive to patients' needs. Nearly a third of clinics were cancelled and patients experienced delays when waiting for their appointments.

Patients who drove themselves to their appointment told us that they found car parking at MDGH was difficult because the demand for spaces was high. The outpatients department had a yellow line on the floor to assist people in finding their clinic from the reception desk; however, this line connected with itself in a loop, so people became confused about their direction or route.

People attending their appointments had to queue to 'book in' at the reception. This meant that people with mobility issues or other disabilities had to wait in line to speak with a receptionist before taking a seat in the waiting room. However, we saw examples of sensitive, appropriate support being provided to those living with dementia.

There was no clear system in the outpatients or diagnostic imaging departments to learn effectively from complaints.

Cancer waiting times were consistently better than the England average for 31-day and 62-day targets. Since September 2013, RTT for patients with incomplete pathways were better than the England average. RTT for non-admitted patients had been inconsistent between April 2013 and May 2014 but were better than the England average from June 2014. Diagnostic waiting times had been better than the England average since November 2013.

Service planning and delivery to meet the needs of local people

- All the patients and relatives we spoke with mentioned the difficulties they had with finding a car parking space.
- The trust had recently reviewed the parking system and had contracted an external management company to manage the car parks. This system had been in place for a number of weeks but patients reported that they were still having a problem parking.
- Senior staff in the outpatients and diagnostic imaging departments told us that the service was flexed to meet the needs of the local people and so they were able to meet the targets set by the trust. This meant, however, that many members of staff were working beyond their contracted hours to provide this service.
- A sister in the outpatients department told us: "We are here for the people attending the clinics and our aim is to provide the best service we can with the resources we have."
- Some service users complained of the cold in the fracture clinic as draughts were caused by the large number of people opening and closing the doors. We noticed that a care assistant moved people who were near the doors in order to keep them warm.
- The outpatients department had a yellow line on the floor to assist people in finding their clinic from the reception desk. However, this line connected with itself in a loop, so people became confused about their direction or route. We assisted two visitors to their destination during our inspection.

Access and flow

- From April 2013 to March 2014, the 'did not attend' rate was consistently better than the England average.
- Cancer waiting times were consistently better than the England average for 31-day and 62-day targets. Since September 2013, RTT for patients with incomplete pathways were better than the England average.
- RTT for non-admitted patients had been inconsistent between April 2013 and May 2014 but were better than the England average from June 2014.
- Diagnostic waiting times had been better than the England average since November 2013.
- Patients told us that the "x-ray department is slick". We were told that people did not have to wait long for their appointments to be arranged. We spoke to nine people waiting for their appointment in the outpatients department and saw that waiting times varied. At one point during the inspection waiting times were up to 50 minutes for appointments.

Outpatients and diagnostic imaging

- We asked the sister in charge of the outpatients department and the manager of the outpatients department what the cancellation figures were; both were unable to give us information on the trust's performance in this area.
- The trust provided us with data stating that 32% of clinics had been cancelled in June 2014 and 31% had been cancelled in May 2014. When we asked about the main reasons for cancellations, the trust told us that this information was unavailable.
- The trust was unable to provide us with data regarding the percentage of patients waiting more than 30 minutes to see a clinician or the percentage of patients seen in outpatients without their full medical record being available.
- We spoke to nine people waiting to attend clinics in the waiting room of the outpatients department. Two patients told us that written correspondence from the hospital following appointments was quick and follow-up appointments were prompt. However, we were told by five patients that clinics had been cancelled and rescheduled at some point at least once.

Meeting people's individual needs

- We saw that expected waiting times were displayed on a whiteboard behind the reception desk. Reception staff did not tell people what the expected waiting time was at the time of booking them in, so people with sight problems may not have been aware of the delay to their appointment.
- One patient told us that they did not know how long the wait for their appointment was, and went to speak to the receptionist to ensure that they had not been forgotten.
- People attending their appointments had to queue to 'book in' at the reception. This meant that people with mobility issues or other disabilities had to wait in line to speak with a receptionist before taking a seat in the waiting room.
- We saw that a person living with dementia was spoken to respectfully by a healthcare assistant and they were given support to relax and orient themself in the unfamiliar surroundings.
- Access to interpretation services was available where required.
- A patient told us that, in the event that their hearing aid required repair, they had to leave the device at the hospital and it would be repaired within 48 hours. However, no alternative device was provided in the meantime, meaning that they could be left for two days without a hearing aid device.

Learning from complaints and concerns

- Written complaints were forwarded to PALS to be managed; however, verbal complaints were dealt with 'in house' and were not documented or reported to the board.
- There was no clear system in the outpatients or diagnostic imaging departments to learn effectively from complaints.
- A skin cancer specialist nurse spoke to us about a complaint where a service user had to wait longer than the four-week target set by the trust. This was escalated to the head of dermatology, and the service user was written to in order to explain how the situation would be managed. A new doctor had been appointed to triage the minor operations list to prevent this happening in the future.
- We spoke to a radiographer in the radiology department who also told us that verbal complaints would not be recorded anywhere.
- We looked at the trust's policy for managing complaints and saw that, although it states that verbal complaints should be dealt with in the department where possible, it also directs that all complaints should be recorded in order for learning from them to take place.

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

The vision and strategy for outpatients and diagnostic imaging services were not clear. Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all risks to service users, and those identified were not being managed effectively. For example, issues such as storage of records in a safe area, challenges with layout, lack of availability of records and the appropriate maintenance of equipment were not being monitored and had not been addressed.

Outpatients and diagnostic imaging

Although staff worked hard to ensure that the service met the requirements of the local people, there was little evidence that there had been trust support and guidance in maintaining the sustainability of the service, particularly in the absence of a department manager. There were clear management structures in place within the outpatients and diagnostic imaging services. However, the outpatients manager was still new in post (two weeks) and we found a lack of effective leadership meant that the service had not identified or managed risks appropriately.

There was a positive culture in the departments; staff were committed and proud of their work. Staff supported each other and there was good multidisciplinary team working within the departments.

Vision and strategy for this service

- The vision and strategy for outpatients and diagnostic imaging services were not clear. The trust's quality strategy for 2013/14 identified improving access to outpatients services as a key priority for 2014/15, but staff were not aware of any significant plans in place to achieve this.
- We spoke to the manager of the outpatients department and asked them about the plans for the future of the department. We were told about recent improvements in the letters sent out from the department, and that issues with staffing, records and the layout of the outpatients department were known risks. However, there were no plans in place to address these matters.
- A radiographer told us that there were extensive plans for the radiology department. We were shown a document regarding the equipment contract renewal that was due to take place in late December and early January. This involved the replacement of most of the imaging equipment the hospital owned with faster equipment.
- We were also told that the radiology department had plans to develop the service to cover a 24-hour period for people in the local area, although we saw no action plans to support this.
- The therapies department worked with Keele University and conducted joint research projects with them to improve the performance of the department. This department showed a clear ambition to improve, but we were told that "the next level up is not supportive in business development".

Governance, risk management and quality measurement

- Governance meetings were held monthly. Senior staff told us that they were a useful mechanism for identifying current themes and issues both within the department and in other departments.
- Although waiting time targets were measured in order to meet government targets, the manager, radiographers, sisters and other senior nurses we spoke with across the departments were unable to identify any other audits or performance measures that were in place to measure performance in other areas and to further improve the service.
- Incidents were not always reported in line with trust policy. This meant that there was a risk that data used to provide the trust with assurance and oversight may not have been accurate or reliable.
- Risk management and quality measurement systems were reactive and not proactive. Outpatients and diagnostic imaging services had not identified all the risks to service users, and those identified were not being managed effectively. For example, issues such as storage of records in a safe area, challenges with layout, lack of availability of records and the appropriate maintenance of equipment were not being monitored and had not been addressed.

Leadership of service

- There were clear management structures in place within the outpatients and diagnostic imaging services. However, the outpatients manager was still new in post (two weeks) and we found a lack of effective leadership meant that the service had not identified or managed risks appropriately.

Culture within the service

- There was a positive culture in the departments. Staff were committed and proud of their work.
- Staff supported each other and there was good multidisciplinary team working within the departments.

Public and staff engagement

- Staff were keen to engage their patients and the public to improve the patient experience.
- Members of the public were invited to leave comments about the service they had received by means of questionnaires.

- We saw that suggestions boxes were available for service users and visitors to post comments. PALS contact details were on display in each area we visited.

Innovation, improvement and sustainability

- We spoke with four senior members of staff in the radiology department and we were told about the future plans for the upgrade of the equipment and the development of the service to operate seven days a week.
- We did not see any evidence of the development of the service from management. The manager had recently been appointed and was unable to provide details of clear goals for the future development of the service in order for it to continually innovate, improve and sustain performance in the long term.
- This meant that, although staff in the clinics worked hard to ensure that the service met the requirements of the local people, there was little evidence that there had been trust support or guidance in maintaining this sustainability, particularly in the absence of a department manager.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Ensure that there are robust systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, in line with requirements.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to children's and young people's services, pain relief documentation in the emergency department and 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.
- Ensure that records in children's and young people's services are stored securely in line with regulatory requirements.
- Ensure that there are effective processes in place for the decontamination and storage of clean and contaminated equipment and for the monitoring of this, particularly in relation to children's and young people's services.
- Ensure that the environment within medical wards, surgical wards and maternity services is well maintained and fit for purpose so that appropriate standards of cleanliness can be maintained.
- Ensure that there are effective systems in place to identify, assess and monitor risks relating to the health, safety and welfare of people who use services and staff. This includes incident-reporting systems and risk management processes for the maintenance of equipment.

Action the hospital SHOULD take to improve

The trust should:

- Consider improving arrangements for clinical supervision to ensure that they are appropriate and support staff to carry out their responsibilities effectively, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.

In urgent and emergency services

- Ensure that four hour wait target data is recorded accurately at the minor injuries unit (MIU) at Congleton War Memorial Hospital.
- Assess all patients for pain relief as they enter the emergency department and ensure that the pain score and any administered pain relief are recorded accurately.
- Review the timeliness of access to interpreter services.
- Review the process to manage bariatric patients.
- Consider implementing a pain audit for paediatrics.

In medical care

- The trust should ensure that mental capacity assessments are recorded appropriately and that all staff understand the requirements of the Mental Capacity Act and deprivation of liberty safeguards.
- The trust should take steps to ensure that all staff are included in lessons learned from incidents and near misses and have a full understanding of the trust's governance processes.
- Action should be taken to ensure that any chemicals are stored appropriately and that 'out of bounds' areas are secured appropriately.

In surgical services

- Take appropriate action to ensure that there is adequate provision of suitable showering facilities for patients within the orthopaedic wards.
- Take appropriate action to ensure that all staff receive clinical mandatory training.
- Take appropriate action to improve performance relating to length of stay for general surgery patients in the hospital.
- Take appropriate action to improve compliance with national targets for 18-week referral-to-treatment time (RTT) standards.
- Consider taking action to ensure that there are appropriate management arrangements in the theatres department.

In critical care

- Consider a review of services to manage patients safely over a 24-hour period.

Outstanding practice and areas for improvement

- Consider reviewing the level of cover provided by consultants to ensure that there are twice daily rounds and that the assessment of admissions to the critical care unit (CCU) can be achieved within the recommended 12-hour period.

In maternity and gynaecology services

- Ensure the safe storage of medical gases, disposable medical equipment and other items on the ward.
- Ensure that risks associated with the use of the birthing pool are assessed and appropriate emergency evacuation equipment is provided.
- Ensure that all staff are up to date with mandatory training.
- Ensure that there are systems for the safe management of patients during operations and in the event of emergencies. This should include joint working with the theatre staff and assurance that midwives who may be requested to assist in theatre are competent to do so.
- Take action to reduce the number of gynaecology operations cancelled at short notice.
- Ensure that the facilities for patients undergoing a termination of pregnancy provide privacy and dignity.

In children's and young people's services

- Ensure that all staff are aware of arrangements for recording and accessing information relating to safeguarding in children's and young people's services. This includes obtaining assurance that consultant assent arrangements are followed in line with trust policy.
- Ensure that staff receive relevant training to support children and young people with mental health needs.
- Ensure that staff are competent and confident in the use of continuous positive airway (CPAP) equipment.
- Ensure that there are monitoring and escalation procedures in place to make sure that there are enough staff with the appropriate skills in order to meet the needs of children and young people.

In end of life care

- Ensure that there are robust arrangements in place for out-of-hours consultant cover and that these arrangements are communicated clearly to all staff, particularly the specialist palliative care team (SPCT).
- Ensure that all staff receive appropriate end of life training.

In outpatients and diagnostic imaging services

- Ensure that equipment is maintained in line with the manufacturers' recommendations.
- Take action to reduce the number of clinic cancellations.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services and others were not protected against the risks associated with the unsafe management and storage of medicines. Regulation 13HSCA 2008 (Regulated Activities) Regulations 2010: Management of medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The provider did not operate effective systems designed to prevent and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment. Regulation 12(2)(a)(c) HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection control

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider did not operate effective systems to identify, assess or monitor risks relating to the health, safety and welfare of people who use services and staff. This included incident-reporting systems and risk management

This section is primarily information for the provider

Compliance actions

processes for the maintenance of equipment. Regulation 10(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Service users were not protected against the risks arising from a lack of proper information about them. The provider did not maintain an accurate record in respect of each service user including appropriate information and documents in relation to the care and treatment provided. The provider did not ensure records were kept securely, particularly in children's and young people's services. Regulation 20 (1) (a) (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010: Records