Tameside Hospital NHS Foundation Trust

Tameside General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Accident and emergency	Good
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Inadequate
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We inspected Tameside NHS Foundation Trust in May 2014 and visited the trust on five separate days both announced and unannounced visits.

The announced visits were 7 and 8 May and the unannounced visits were 13, 16 and 17 May 2014. This was a full comprehensive inspection.

The inspection team inspected the following core services :

- Accident and Emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive / Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

This inspection was a comprehensive inspection, which took note of the previous inspection in January 2014, to monitor the trust's improvements in meeting the regulations.

We noted that there was a positive culture towards improvement and change amongst senior and service managers. We witnessed services beginning to address the challenges they faced. This report recognises many of those challenges the services face and some of the work already underway to address these.

We saw that the trust was on a journey of improvement. We saw that the staff at many levels were committed to that improvement and were beginning to work as part of a cohesive team.

We were impressed by the integration of working. This reputation had spread and the trust was recruiting staff from other trusts on the back of a growing reputation.

Overall however, we found that the services provided by the trust were currently inadequate. Our key findings were as follows:

- We found a service improved from the assessment made at the time of the Keogh Review
- We found that caring was good across all areas of the organisation.
- We found staff to be committed to making improvements.
- We found a strong and visible Executive Team providing leadership to the organisation and driving delivery of the improvement plan.
- We found that A&E, maternity services and children's/young people's services were good.
- We found that critical care services were inadequate including: lack of availability of national audit (ICNARC) data, incident reporting and feedback, record keeping, equipment and patient monitoring.
- We found that parts of medical care services required improvement, including: aspects of medication processes, record keeping and medical staffing.

Summary of findings

- We found some elements of surgical care required improvement including monitoring and management of preoperative patients.
- Despite many improvements already made we found that elements of outpatient care required improvement including clinic organisation and efficiency of booking processes. The implementation of the new Lorenzo record system was of most concern.

We saw several areas of outstanding practice including:

- The children's unit development that included significant user and community involvement in its design.
- The trust had an outside garden area for patients which was dementia-friendly.
- The trust welcomed visits by patient groups, such as Healthwatch or Tameside Hospital Action Group, to see for themselves how the hospital was performing.
- Patients were assessed regarding their rehabilitation needs and the physiotherapy team were available seven days a week to contribute to meeting the goals for each patient's recovery. The physiotherapy team was led by a consultant in physiotherapy so that a senior person was available regarding complex issues.
- One of the hospital's community midwives had recently won the British Journal of Midwifery's Community Midwife of the Year Award. This midwife had been recognised for recently supporting four women with cancer during their pregnancies and reportedly, "Continually goes that extra mile to support women and their families", said the head of midwifery.
- In 2012, the maternity unit launched a fundraising campaign called the Bright Start appeal. This highly successful campaign had funded the development of the birthing pool room and would fund the future development of the midwifery-led birth room.
- The maternity service actively participated in national research and audit projects. This included: "The Healthy Eating and Lifestyle in Pregnancy Study" which was being undertaken with Cardiff University and Slimming World; "The Building Blocks: A trial of Home Visits for first time mothers" in partnership with University Hospital South Manchester and "The Bumpes Trial" which was being undertaken by the University College London.
- The facilities for bereaved parents included a private room, garden and en suite bathroom. The room contained a television, lounge, kitchen and hot beverage facilities. A midwife, usually bereavement trained, was allocated to the family whilst in hospital. After being discharged from hospital, the nurse visited the family at home or contacted them by telephone. The trust held an annual forget-me-not remembrance service.
- The maternity service had developed a teenage pregnancy reduction initiative in response to local need which had a positive impact in reducing the number of teenagers who were expecting their second child. The trust appointed a specialist teenage pregnancy midwife, created a more teen friendly environment and improved the continuity of care from staff.
- The trust worked creatively with commissioners and other trusts to plan new ways of meeting the needs of children and young people. Together, they developed integrated pathways of care, particularly for children and young people with multiple or complex needs.
- The trust had a dedicated children's safeguarding team which evidenced proactive outreach programmes and service adaptations aimed at meeting the needs of people in vulnerable circumstances.
- The trust developed an observation and assessment unit and community nursing team for children and young people, which significantly reduced hospital admissions and accident and emergency department attendance.
- The trust raised the profile of end of life care by appointing an end of life care facilitator who worked with other staff and external agencies to implement best practice in the mortuary and chaplaincy service, improve care on the wards and facilitate rapid discharge.
- The trust had adapted the equipment used for transporting deceased patients to resemble an empty bed. This was discreet and made for a dignified journey through the hospital to the mortuary.
- The trust had three syringe drivers available for the sole purpose of facilitating a rapid discharge for any patient who required this equipment, which was normally supplied by community services.

Summary of findings

- The trust's paediatric outpatient department provided a stimulating and interesting environment in the waiting, consultation and treatment areas. This environment had been designed as a result of consultation with a local primary school so that it appealed to children and young people. This included small details, such as a glass cabinet in the reception desk where a toy replica of a hospital was placed to reduce the boredom of children when they were waiting at the desk.
- The trust had an electronic system for logging and identifying patient records, which resulted in improved access to records for outpatient clinics.

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

- take action to ensure that within critical care they have safely stored adequate supplies of medication and that staff regularly check this.
- take action to ensure that staff, particularly in maternity, safely administer and dispose of medications, that staff accurately record this, and that staff regularly check these records.
- take action to ensure that patient records, such as nursing assessments, procedure books, patient group directives or discharge letters, are accurate and fit for purpose.
- take action to ensure that staff promptly assess all patients and ensure their welfare and safety, particularly in A&E.
- take action to ensure staff accurately and regularly check equipment such as resuscitation trolleys across all areas of the trust's building on the good practice in many areas.
- take action to ensure that the practice of learning from complaints is embedded across the trust, building on the good practice already in place in some areas as they learn from complaints and concerns .
- take action to ensure that staff adequately assess and respond to changes in patient condition or risk.
- take action to ensure that the environment for interventional procedures in coronary care are safe and suitable for treatment.

In addition the trust should:

- ensure that all staff (particularly in medical care services and A&E) receive suitable structured supervision building on the work already in place.
- ensure that all staff, patients and visitors know how to respond to any allegation of abuse.
- ensure that staff provide external identification for patients, such as a wristband, when patients arrive in the A&E department.
- ensure that the trust improves the routine monitoring of the care and treatment of patients waiting in the A&E department.
- ensure that staff (particularly in medical care services) have adequate plans in place to care for people with mental health conditions, including dementia, or challenging behaviour.
- ensure staff are aware of all appropriate equipment in critical care and how to ensure this is available and promptly repaired if broken.
- ensure that their Intensive Care National Audit & Research Centre data is kept up to date and used proactively to help monitor the safety, effectiveness and responsiveness of the service.
- ensure there are robust systems in place to obtain the views of patients and carers regarding care at the end of life and bereavement support.
- consider how they support staff to quickly identify clean versus dirty equipment; particularly in maternity, children's services and medical care services.
- consider how they work together with the local community to facilitate safe and prompt discharges.
- consider how staff in the MHDU/CCU adequately monitor the weight of patients who cannot easily stand.
- consider the impact of having nurses with combined anaesthetic and recovery responsibilities .
- consider how their plans for re-developing the critical care service meets the needs of staff and patients.

Summary of findings

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?
Accident and emergency	Good 	The A&E department had professional, caring, positive and enthusiastic staff members. Whilst they are not meeting all the clinical quality indicators and there are gaps, for example, in assessing pain and record keeping staff are working hard to make improvements and are proud of the service they provide to patients. Staff said the culture of the department has changed significantly, they feel listened to and respected for the work they do. The service didn't always monitor and record well the observations on patients waiting in the service. Additionally, pain assessment and pain scores are not routinely carried out and recorded.
Medical care	Requires improvement 	Some staff required greater understanding of the clinical management of deteriorating patients. admitted to their wards or units. They did not always adequately assess, monitor or manage risks to the patient or assess patients' needs or deliver care and treatment in line with current, standards, and national or internationally recognised evidence-based guidance. Medical staff were concerned about the number of doctors available and the use of agency. Delays in consultant reviews were reported to us. Junior doctors told us of the number of shifts they worked. Some patients experienced delays throughout their stay in hospital and were not always admitted to the right ward to meet their needs. The outcomes for patients, in some clinical areas, were poor compared to other services. This was mitigated somewhat by shared learning among clinical staff and the presence of cross-cutting staff, such as the outreach team and specialist nurses. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations. This had a positive impact on patient experience. Most people spoke positively about their recent experiences at the hospital, giving examples of how staff treated people with kindness, dignity, respect, compassion and empathy while providing care and

Summary of findings

			treatment. The trust's governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks within the service. These arrangements were still very new, but the trust's track record on safety was improving. The trust had taken steps to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment.
Surgery	**Requires improvement**		People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust took steps to engage with people who used the service, public and staff, however, more work was needed to ensure that people had all relevant information and that the trust received and acted on their feedback. Many staff were clear about their responsibilities and identified, understood and managed risks, but the trust did not yet have an embedded system in place to ensure that all staff regularly considered quality and performance (e.g. with patient flow). Patient access to surgery was limited by hospital capacity; this resulted in last-minute changes to the theatre lists. Patient flow was sometimes disorganised, resulting in poor patient experience of the service. The trust's track record on safety demonstrated improvements. Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. Staff followed a robust infection control policy and used well-equipped decontamination facilities. The trust learned when things went wrong and improved safety standards as a result, although more work was needed to ensure staff reported incidents appropriately. The patient-reported outcomes (PROMS) for people using the service were good, with exception of knee and hip surgery, which were poor compared to other hospitals.
Critical care	**Inadequate**		Staff were caring but the trust did not plan and deliver its services to meet the needs of local people. The documentation available for staff to record patients' care was not designed for use in a critical care service. Patients did not consistently have

access to timely assessments by medical intensive care specialists. The overall space available in the unit was limited and some key equipment was incomplete or unavailable. The occupancy levels were above the England average. 70% of nurses in the intensive treatment unit had completed their post-registration intensive care training although there are plans in place for the remainder to complete the training. Recruitment of a critical care educator is underway. Patients were routinely cared for in CCU by a team of nurses who did not always have the appropriate skill mix. During the patient's recovery, patients had an outstanding level of access to physiotherapists, whereas patients' access to speech and language therapists did not meet best practice standards.

Although they had plans to reorganise the service, the trust did not have a credible strategy to deliver high-quality care and promote good outcomes for people in critical care. The trust could improve the systems for monitoring incidents and safety. Senior managers were not aware of the issues relating to capacity and staffing in the critical care service. These concerns did not feature in the trust's risk registers and had not been adequately considered in the strategic plans for the critical care service. The trust had not collected the relevant performance data to assist the trust in monitoring the service nor adequately engaged with staff.

Patients and their families said staff were attentive and caring. Staff worked well as a team, felt supported by their line managers, and were highly motivated to provide patients with the best care possible. They treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. People and those close to them spoke positively about their experience in critical care. However, we were unable to measure the satisfaction (outcomes) for people using the service, as the trust did not have an adequate system in place to monitor them.

Maternity and family planning

Good

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for women. The service was actively involved in national and local research and audit projects. The trust engaged with women, the public

and staff and acted on their feedback. The outcomes for people using the service were good compared to other services, although fewer women chose to breastfeed their babies at birth, compared to the national average. The trust had received multiple awards for providing women and those close to them the support they needed to cope emotionally with their care and treatment.
The trust's track record on safety was generally good. Women were cared for by suitably qualified and competent staff, although sickness levels were high and the proportion of staff who had participated in mandatory training was significantly below trust targets. The trust planned and delivered its services to meet the needs of the local population, such as appointing specialist midwives or providing additional clinics. They anticipated potential risks to the service and developed plans in advance to manage these risks. They learned when things went wrong and improved safety standards as a result. However, staff did not maintain accurate records regarding consultant cover, equipment checks, or the management of controlled drugs.

Services for children and young people

Good

The trust paid attention to detail when designing the service appearance and facilities, which catered for all ages of children and young people. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. Children, young people, parents and carers praised the caring approach of staff. The service learned when things went wrong and improved safety standards as a result. However, the service's proportion of staff whose had completed their mandatory training was below trust targets. Some potential and relatively minor risks to the service had not been anticipated or planned for in advance, such as access to the neonatal unit which although security was in place it could be improved . Staff were not consistently checking neonatal resuscitation equipment and storage of controlled drugs. The outcomes for people using the service were generally good.
The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for children and young people. The trust engaged with children, young people, families, the

Summary of findings

public and staff, seeking and acting on their feedback to improve the quality of the service. Staff worked closely with external agencies to ensure that care delivery was seamless and tailored specifically to individual needs. The culture within the service reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The leaders of the service particularly encouraged staff to be innovative, caring and cooperative. People's comments and complaints were catalysts for service improvement.

End of life care

Requires improvement

The trust was in the process of developing its end of life care service, following changes to best practice guidance. As a result, some staff felt less confident about providing effective care for patients at the end of life. There was good provision for out-of-hours support from palliative care specialists, however, not all staff were aware of how to obtain it. The trust had improved the way staff took account of people's needs and wishes at the end of their lives, including at referral, admission, discharge and at transitions. The mortuary provided a respectful and dignified service to the deceased patient and their families. The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for people. There had been changes to the senior management team in end of life care which raised the profile of end of life care within the trust. The trust took adequate steps to learn continually and improve, such as providing syringe drivers to promote rapid discharge for patients who wish to die at home. They supported safe innovation to ensure the future sustainability and quality of end of life care, such as working with other local trusts to develop an advanced care plan. However, there were inconsistencies in how staff implemented the policies or guidance. Information on the outcomes for people using the service was limited.

Outpatients

Requires improvement

The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment. However, staff in some areas felt that low staffing numbers had a negative impact on patient experience. The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. However,

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delays in the triaging of referrals meant that the trust did not take adequate steps to reduce delays for patients who urgently needed investigations. The trust did not have adequate systems in place to monitor the satisfaction (outcomes) for people.. Although the children's outpatient service was responsive to the needs of children, parents and carers, the trust did not have an adequate system in place to deliver its outpatient services to meet the needs of adults. Adults sometimes experienced long waits and did not receive accurate information about their appointments. The trust did not take adequate steps to ensure that people accessed its services in a timely way. The trust was aware of the concerns around access and flow and had put short-term measures in place to improve the service. They had recently begun a project to audit the service and make improvements in clinic productivity and patient experience. Staff were working towards the project objectives. As these arrangements were new, the trust was not able to ensure that staff were clear about their responsibilities, that staff regularly considered quality and performance, and that staff identified, understood and managed risks.

Inadequate

Tameside General HospitalTameside General Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

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Detailed findings

Background to Tameside General Hospital

Tameside Hospital NHS Foundation Trust is a major provider of community and hospital services in Tameside and Glossop, providing care to a population of 250,000. The trust had approximately 2,300 staff and 524 beds in total in one acute hospital site situated in Ashton–under-Lyne. In 2012/13, the trust saw 52,452 inpatients, 241,040 outpatients, and 78,118 people attending Accident and Emergency.

Tameside includes Tameside Metropolitan Borough Council and Derbyshire Council. Tameside is an urban area with 9% non-white minorities, according to the 2011 Census for England and Wales. It ranked 42nd out of 326 local authorities in terms of deprivation and people living in Tameside have a worse than average life expectancy.

Tameside Hospital NHS Foundation Trust was established on 1 February 2008. Previously, the trust operated as Tameside and Glossop Acute Services NHS Trust since 1994. It became a foundation trust in 2008.

The inspection team inspected the following core services :

- Accident and Emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive / Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

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

This inspection was a comprehensive inspection, which took note of the previous inspection in January 2014, to monitor the trust's improvements in meeting the regulations.

Our inspection team

Our inspection team was led by:

Chair: Peter Blythin, Director of Nursing, NHS Trust Development Authority

Head of Hospital Inspections: Tim Cooper, Care Quality Commission
(CQC)

The team of over 30 people included CQC inspectors, doctors and nurses with specialist skills and interests in the areas we inspected. There were people with skills and experience to look at safeguarding and care of vulnerable adults. There were at least two members of the team who also held board level roles in other trusts and therefore were experienced in the wider organisational issues. We had both a junior doctor and a student nurse. Additionally we had two experts by experience (people with experience of services who are able to represent the patients voice). Two Mental Health Act commissioners also visited the hospital, to review how the trust supported staff to meet the requirements of the Mental Health Act 1983.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We also held an off-site listening event in Ashton-under-Lyne on 6 May 2014 which was attended by twelve people. We also met with five governors of the hospital.

We carried out an announced inspection visit on 7 and 8 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior 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 outpatient 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 carried out unannounced inspections on Monday 12 May 2014, Friday 17 May 2014 and Saturday 18 May 2014. This included an out-of-hours inspection. We looked at how the hospital was run at night, the levels and type of staff available, and how they cared for patients.

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 Tameside General Hospital.

Facts and data about Tameside General Hospital

Tameside Hospital NHS Foundation Trust has only one location, Tameside General Hospital, currently registered with the Care Quality Commission which has been inspected nine times since 2010, with the last inspection in January 2014. The location was found to be non-compliant on eight regulations out of the 11 regulations inspected.

The trust board is accountable for setting the strategic direction, monitoring of performance against objectives and ensuring high standards of corporate governance as well as helping to promote links between trust and the local community. The trust chairman was Paul Connellan. The trust interim chief executive was Karen James. Other executive directors included: Barbara Herring (director of finance), Brendan Ryan (interim medical director), John Goodenough (director of nursing), and Paul Williams (chief operating officer).

Bed occupancy is defined as the percentage of available beds occupied overnight. Prior to July 2013, Tameside General Hospital's bed occupancy percentages (between 85% and 90%) were consistently above England average (around 85%). However, the hospital had 85% bed occupancy between October and December 2013. The percentage of adult critical care beds occupied (88%) was above the England average for this period (83%).

Tameside General Hospital is located within ten miles of four other acute hospitals.

Tameside is a metropolitan borough in Greater Manchester, North West England. Tameside is bordered by the metropolitan boroughs of Stockport and Oldham, the city of Manchester and the borough of High Peak in Derbyshire. The 2010 Indices of Deprivation showed that Tameside was the 42nd most deprived local authority

Detailed findings

(out of 326 local authorities, with 1st being the most deprived). Between 2007 and 2010 the deprivation score for Tameside increased meaning that the level of deprivation worsened. Census data shows an increasing population and a lower than average proportion of Black, Asian and Minority Ethnic (BAME) residents. In Tameside, 9.1% belong to non-White minorities. Of these, Asian constitutes the largest ethnic group with 6.6% of the population.

Life expectancy was 10.4 years lower for men and 8.8 years lower for women in the most deprived areas of Tameside than in the least deprived areas. Over the years, all causes of mortality rates have fallen such as early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average.

The GP registration data shows that 98.9% of the population of Tameside are registered with a GP. According to health profiles, the health of people in Tameside was generally worse than the England average. In Year 6, 19.7% of children were classified as obese and estimated levels of adult 'healthy eating', smoking, physical activity and obesity were worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm were worse than the England average. But the rate of road injuries and deaths was better than the England average.

The trust completed its Health Investment in Tameside (HIT) project in December 2010 which involved the comprehensive restructuring of the hospital site. Most of the older buildings have been demolished and replaced with new, state-of- the-art facilities. These facilities include new wards, new inpatient and day case theatres, new outpatient clinics, new diagnostic departments (including new x-ray facilities), a new pharmacy and a new integrated children's unit.

The trust provides a wide array of services associated with a general hospital. These services include general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric hospital services for women, children and babies.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Good	Good	Good
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Maternity and family planning	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Inadequate	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Requires improvement	Inadequate	Good	Inadequate

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency and Outpatients.

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department at Tameside General Hospital provides a 24 hour seven day a week service to the local area of approximately 250 000 population. It sees around 80,000 to 90,000 patients a year approximately 200 – 250 patients a day.

Patients present to the department either by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot they are seen at the reception by a receptionist who clerks the patient in. They are then seen by a band 5 or 6 nurse who triages the patient within 15 minutes, if the patient is a priority the reception will flag this and the patient will be seen sooner than this. The paediatric reception operates from 10am till 10pm; outside these hours' children are seen at the main reception. If a patient arrives by ambulance they are transferred either into majors or into resuscitation. The department itself consists of 4 main areas, minors which has ten cubicles, majors which has twelve cubicles all of which have cardiac monitoring, a resuscitation area, with 5 cubicles and a paediatric area with 4 cubicles. There is also a room for relatives and this is located close to majors. This room is bright and clean with comfortable seating for families who have to wait particularly long periods of time. There is also a mental health assessment room.

We inspected all areas of A&E and spoke to over twenty patients and relatives, approximately forty staff, which included nurses, doctors, consultants, the department manager, therapists, security, support and ambulance staff. We observed care and treatment and looked at approximately ten care records. We received comments from the listening event and from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

Accident and emergency

Summary of findings

The A&E department had professional, caring, positive and enthusiastic staff members. Whilst they are not meeting all the clinical quality indicators and there are gaps, for example, in assessing pain and record keeping staff are working hard to make improvements and are proud of the service they provide to patients.

Staff said the culture of the department has changed significantly, they feel listened to and respected for the work they do.

The service didn't always monitor and record well the observations on patients waiting in the service. Additionally, pain assessment and pain scores are not routinely carried out and recorded.

Are accident and emergency services safe?

Requires improvement

The A&E department was comfortable with a large waiting area with a wall mounted television, toilet facilities including a disabled toilet, and drinks and food vending machine. However, on the day of the inspection the cold drinks dispensing machine was out of order. There is an electronic incident reporting system that was easy to use and staff were aware of it, used it and received feedback on incident and complaints at the bi weekly clinical governance meeting. The cubicles were well stocked and equipment was maintained and up to date, however, recording of daily checks for crash trolleys were not seen.

Department audits showed that record keeping including initial assessment and observations were not robust. Wrist bands were not put on patients after their initial assessment, in a thirty minute period we observed 4 patients who did not have wrist bands. Patient group directives were out of date and this was reported to the director of nursing immediately and action taken. The introduction of a rapid assessment team (REACT) for majors led by a consultant was seen as a welcome introduction since March 2014 and a good learning experience for those who are involved in this assessment of patients.

Incidents

- There had been 11 moderate patient safety incidents and one death in A&E reported to the National Reporting Learning System (NRLS) between June 2012 and May 2013.
- Eighty incidents were reported in A&E during the month of April 2014. The triggers ranged from clinical care, consent, equipment failures, information technology problems and medical errors. These were graded from one to five with five being catastrophic resulting in a death. A band 7 nurse was investigating a recent incident that had resulted in death, by performing a root cause analysis.

Accident and emergency

- Staff reported incidents through an electronic system that was easier to use and much quicker than the old paper system. The induction manual encouraged doctors to report incidents.
- Managers communicated learning and changes to practice through bi weekly clinical governance meetings. Staff who reported incidents stated that they did not always receive specific feedback.
- Fourteen deaths were reported in March 2014 of which 10 arrived in established cardiac arrest and four died in the department of other causes. In line with good practice all deaths were investigated by a dedicated team member and reviewed in a trust committee on mortality.
- CQI Data for A&E April 2013 to March 2014 show the targets for unplanned re attendances to the department within seven days and discharge letters within 24 hours of discharge were met.

Cleanliness, infection control and hygiene

- The department was clean and staff used hand hygiene gel and personal protective equipment such as gloves and aprons.
- Cleaners were visible and cleaning schedules were displayed on the cleaners' door. Cleaners left messages for each other regarding the areas that needed attending in the next shift.
- Patients with known infections such as clostridium difficile were barrier nursed in a side room.
- Hand hygiene audits were carried out weekly but the results were not shared with staff nor displayed for public information.

Environment and equipment

- Overall, the A&E environment was found to be spacious, well equipped and uncluttered.
- The children's waiting area was large and contained toys and activities to occupy them. However a door opened into this area from the resuscitation corridor, which was used by ambulance crews to deliver paperwork to reception. This posed a risk to injury for children in the waiting area.
- There was a mental health assessment room with two doors, opening in and out. This room was dark in décor (which research shows may be calming and beneficial) with a number of stacked plastic chairs. There were potential ligature points, which meant that patients were put at risk of harm.
- There was an overflowing sharps box on a blood taking trolley which was 'shaken down' but not closed or replaced.
- Resuscitation trolley records were not updated to reflect regular checks. There were a large number of omissions in the records for three of the four trolleys in the department.
- Overall the department had sufficient equipment to monitor patients, such as cardiac monitors.
- All the cubicles in resuscitation had suitable equipment trolleys, ventilators and monitoring, one bay was equipped to take paediatric patients.

Medicines

- Medicines were stored correctly in locked cupboards and fridges.
- Patient group directives, which allowed the nursing staff to issue specific pain-relieving medication to patients without seeing a doctor, were found to be out of date (dated 2006). The directives did not specify doses of medications to be administered or the ages of children that these medications could be given to. This issue was escalated during the inspection to the director of nursing who acknowledged that they needed updating. Action was taken following this.

Records

- We looked at 20 set of notes during our inspection.
- Some records were incomplete or did not demonstrate that patients were adequately monitored. One frail patient had been in the A&E for eight hours, sat on a chair, but there was only one set of observations and one entry in the nursing documentation. The patient was awaiting transfer to the ward.
- A records audit carried out in January and February 2014 records audit had identified that not all patients had completed the patient at risk score (PARS) and the paediatric early warning score (PEWS). Records seen on the inspection confirmed these findings. One patient had no nursing assessment. Another patient had no physical observations on arrival and lacked an assessment of their pain.
- Staff did not always adequately respond to alerts for children on safeguarding risk registers. They did not always appear to check if the child had a social worker, despite this being prompted by relevant proforma.

Accident and emergency

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies relating to the safety of carers and patients, such as, control and restraint and the management of violence.
- Staff had a good understanding of the Mental Capacity Act 2005 and were able to describe how they would assess capacity and what action to take when patients lacked capacity.
- Staff said there were a number of incidents in A&E regarding patients with mental health needs absconding (leaving the trust while under section by the Mental Health Act or before receiving assessment, care and treatment).
- Staff attended mandatory training on consent, which was also provided as part of the local induction for doctors.

Safeguarding

- Staff said they used the trust safeguarding policy and had received training in safeguarding.
- A staff member followed this policy by reporting a safeguarding incident for a patient who had attended A&E with a fractured femur.
- There was a nursing champion for safeguarding in the department.

Mandatory training

- Mandatory training for the department was reported as being good. Staff were kept up to date, by emailed alerts when training was due. Courses were posted on staff room notice boards for people to add their names.
- The department held study days in March and April 2014 which covered topics such as safeguarding, alcohol screening, domestic violence and capacity. Control and restraint training was also offered.
- Staff said that they could access further training if they were able to demonstrate how this would be relevant to their role.

Assessing and responding to patient risk

- Patients presented to the department either by walking into the reception area or arriving by ambulance. If a patient arrived in the department on foot they were seen at the reception by a receptionist who clerks the patient in. They were then seen by a band 5 nurse who triaged the patient within fifteen minutes or sooner should the receptionist request it.
- During 10am to 10pm children check in at the paediatric reception area adjacent to the main reception. This was available seven days a week although if there was no receptionist children would be directed to the main reception.
- Patients arriving as a priority call (blue light) were transferred immediately through to the resuscitation area. The REACT led by a consultant would rapidly assess all patients admitted to majors. The REACT was available 8 am to 4 pm Monday to Friday.
- Three patients did not have wristbands put on immediately when they arrived in the department. This meant that if the patient deteriorated staff would not know the name of the patient that had been assessed.
- When there were three patients waiting in the corridor on trolleys this would be escalated to the person in charge at that time so other options for managing patients could be considered.
- When the A&E department became busy, patients waiting to be seen in majors were kept on trolleys in the corridor. Three patients were in the corridor for over one hour. One of these patients waited 75 minutes without being seen or checked by staff. Staff said that they aimed to ensure patients stayed no longer than 30 minutes in the corridor.
- There is an escalation protocol that was triggered when a patient had not been seen by a doctor for three hours.
- There was a programme of audits undertaken in the department. An audit of two hundred records from January and February 2014 identified that seventy eight had no PARS or PEWS recorded. In ninety one records, the signature was not recognisable. Six study days had been held to address this issue.

Nursing staffing

- The allocation of staff depended on workload. Nurses worked 12.5 hour shifts. The funded establishment was 14 registered nurses, four health care assistants, two emergency nurse practitioners and two paediatric nurses on duty. At night there were 11 registered nurses until midnight and then 10 until 8 am. The emergency nurse practitioners went off duty at 9 pm.
- A&E used their own bank staff or agency staff familiar to the unit. The trust aimed to reduce the reliance on agency staff. Two agency nurses recently applied for substantive posts. A nurse said “recruitment is 100% better than it was.”

Accident and emergency

Medical staffing

- There are seven whole time equivalent (WTE) consultants who share cover from 8 am to 8 pm at night, seven days a week. If the department is busy, the on call consultant will stay later if needed and then would be available by phone. The medical rota was on display in a glass cabinet in the majors area.
- The seven consultants operate with an on-call consultant rota. There is consultant presence in ED from 08.00 to 20.00 Monday to Friday and from 20.00 to 08.00 on call from home. At weekends the Consultant presence is 08.00 to 18.00, followed by the on-call service from 18.00 to 08.00. The on-call consultant is available from home to advise clinically or alternative be requested to attend the department where deemed necessary.
- There was evidence of A&E consultant and acute medical consultant cover within the department.
- The doctors; one middle grade, one foundation year 2 trainee and one locum spoken to said they felt well-supported, inducted and were happy to be working in the department.
- The handover of patients to the medical assessment unit was done over the phone although getting through was problematic. A proforma was completed that goes with the patient.
- There was an established handover of majors and resuscitation patients at 4 pm on a weekday facilitated by the consultant on call that day. All doctors dealing with patients in these areas were expected to attend this handover.

Major incident awareness and training

- The major incident policy was available to staff in the A&E and also on the intranet.
- There were three on site security personnel who could be 'fast bleeped' in the event of an emergency. They regularly patrolled the hospital.
- The reception was a closed space with a desk to ceiling glass front.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

There are a number of care bundles and clinical pathways in use. The department is failing to meet all the national clinical quality indicators, for example the targets for unplanned re attendances. Pain assessment and pain scores are not routinely carried out and recorded. The board round is well attended by the multidisciplinary team and staff in the department are competent with supervision and learning seen by staff as positive.

Evidence-based care and treatment

- There was evidence of nurses using national institute of clinical excellence (NICE) guidelines and sharing them with the doctors.
- There were twenty five care bundles for adults and five for paediatrics. These have been in place since 2012 and the feedback from doctors and nurses was good. These were available on the intranet and there were paper copies in every cubicle and treatment area. The result of the last audit was 92% compliance.
- There were seven active clinical pathways in respect of the ambulatory emergency care clinic, these include urinary tract infections, deep vein thrombosis and chest pain.
- Data provided by the trust showed that the A&E department was failing to meet targets five out of six clinical quality indicators (CQI) for Feb 2014.
- CQI data for initial assessment within 15 minutes and treatment within 60 minutes of arrival both fail to meet targets overall. However the data shows that performance to achieve the targets for treatment within sixty minutes of arrival has improved on the performance figures for 2012 to 2013. The trust is working to improve its data quality and work on this is underway.
- The A&E department achieved its target for patients being admitted or discharged within four hours of arrival in seven out of twelve months for the year 2013 to 2014.

Accident and emergency

Pain relief

- One relative said it took over four hours for the patient to be given pain relief; they had come in from a care home and had had a fall resulting in a fractured neck of femur. This could not be clinically substantiated, but clearly left the relative with anxiety.
- Pain assessments were not carried out routinely by some staff which meant that patients could be in pain for a considerable length of time. Triage nurses were reminded to record the pain score as this was not routinely carried out.

Nutrition and hydration

- There were four auxiliaries in A&E who checked on whether patients had had a drink and food. They checked with a nurse before providing food or drink to the patient.

Patient outcomes

- A cardiac arrest audit was carried out for the whole hospital but the trust was not part of a national cardiac arrest audit (NCAA) in 2012/13. The trust has participated in 2013/14.
- The stroke pathway operated during the day. The stroke nurse attended and was available until 7 pm. Ambulances then divert patients who have had a stroke to other hospitals.
- There is a mental health assessment tool (red, amber or green) that is used to assess the risk of self - harm; if the outcome is red a member of security is called to supervise the patient. Security personnel were reported as very good at managing these patients. Psychiatric patients now have a welfare form completed.

Competent staff

- Nurses specialising in chest pain work in the A&E, normally from 8am to 4pm, seven days a week. Additional cover may be provided between 07:30am and 07:30pm depending on rota allocation; this is not consistently planned.
- Consultant supervision was good and junior doctors were not allowed to work nights until after they had been in post for six weeks.
- Feedback given by doctors was that REACT was a good learning experience.
- Appraisals were carried out. The results of the 2013 NHS Staff Survey indicated that the overall percentage of trust appraisals was better than expected.
- We observed a board round attended by a multidisciplinary team where the salient points of all the patient's in majors were discussed. At the board round both the lead consultant for A&E and the consultant for the medical admissions unit were present.

Multidisciplinary working

- Board rounds were held every four hours and were attended by the multi-disciplinary team. The meeting we observed was quick, well attended and led by a consultant. We did not hear any discussions about pain control.
- Including occupational therapy, physiotherapy and social workers in board rounds has enabled speedier creation of care packages so that patients can be discharged to the community quicker.
- Use of evidence based practice was helped by the presence of a librarian at the 4 pm board round to help staff access research information.
- When required other doctors from other specialities came to the department and saw patients, we observed a respiratory medicine doctor amongst other physicians in the resuscitation room seeing patients. One doctor said the barrier between A&E and the medical assessment unit have been broken down and the desire for the two departments to work collaboratively is strong. They see themselves to be part of the Urgent Care 'family'.

Seven-day services

- Radiology and pharmacy services were available twenty four hours a day seven days a week. Occupational therapy and physiotherapy were on call services only. A radiographer said that out of hours scanning was available within 30 minutes and earlier for brain scans if a suitably trained radiographer was on duty.

Are accident and emergency services caring?

Good

Although patients told us that they felt staff were caring the trust scored significantly lower in the A&E Friend and Family Test than the national average although the response rate was low. Throughout our visit we observed staff of all grades to be polite, friendly and responsive to patients, relatives and each other.

Accident and emergency

Compassionate care

- Staff of all grades, qualified and unqualified were polite, friendly and responsive to patients needs when requested.
- A mother spoken to in the paediatric waiting area with her twelve year old son was happy with the care and prompt assessment he had received. Another patient who had been to A&E a number of times said they were happy with the service and would recommend it to family and friends.
- We witnessed multiple episodes of patient and staff interaction, during which staff were observed treating patients with compassion.
- Staff lowered their voices to prevent from being overheard. Privacy signs were used on curtains to prevent staff from entering and we saw staff check before they did.
- Data showed that the Friends and Family Test for A&E had a low response rate and scores from results were well below the England averages.

Patient understanding and involvement

- We observed staff to be warm and sensitive to both patients and relatives. We heard a doctor who took care to explain in detail to a patient what was wrong, what he was going to do next and where the patient would be transferred to.

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

Good

Staff are working hard to improve the flow of patients through the department, for example, close working with staff in the community, ensuring that communication and handover of patients between the department and the medical admissions unit is strengthened and the early involvement of the mental health assessment team for patients with mental health needs.

Service planning and delivery to meet the needs of local people

- Referring a patient to another specialty must be done within a maximum of three hours after the patient is booked into A&E.
- A staff suggestion to change a store room into ambulance assessment area has been done. This has helped improve patient flow with a decreased hand over time from ambulance to A&E. It also improved dignity and confidentiality for patients as they are no longer assessed in the corridor. Ambulance crews we spoke to said this had dramatically shortened their hand over times.
- There is a POD (air transport) system in place to transfer diagnostic specimens to pathology and receive medication from pharmacy, this helped speed up discharge by getting results and patient medication back to the department quicker.
- Community support teams were available to support the discharge of patients.
- The ambulatory emergency care clinic located within the medical admissions unit has helped patient flow. This unit was a short stay place and used for treating non-urgent patients.
- A hospital ambulance liaison officer (HALO) was called to the department to assist when there are blockages in the system, for example, transferring patients out of A&E.
- The hospital has a contract with St Johns Ambulance who were reported as being very responsive, they will take patients back to their home once ready to be discharged if required.

Access and flow

- Patients presented to the department either by walking into the reception area or by arriving by ambulance. If a patient arrived in the department on foot they were seen at the reception by a receptionist who clerked the patient in. They were then seen by a band 5 or 6 nurse who triaged the patient within 15 minutes, so that patients could be assessed and treated according to their risk.
- Flow management within majors was managed using a whiteboard and plaques. This did not seem a reliable mechanism for keeping track of patients. Given the visibility of the board this was breaking Caldicott guidance. The trust were planning to move to an electronic tracking system.
- The trusts A&E performance of transferring or discharging 95% of patients within four hours of their arrival in A&E was poorer at the end of winter 2013/2014

than the start with a level as low as 85.5% on 2 March 2014. Performance has improved, but there are still significant dips below target. Overall, the trust is meeting its quarterly target.
- The departments performance on the four hour national target in the winter 2013/2014 was better than in the winter 2012/2013.
- Over an eight month period there had been a reduction in Ambulance turnaround times in excess of 30 minutes by 50%.
- The waiting times were displayed within the reception area but this is not easy to see.

Meeting people's individual needs

- Translation services were available and a translation folder was available in majors.
- Patients with mental health needs are identified at triage and there was a room for these patients to be assessed (since April 2014).
- There was generally more collaboration with colleagues in social and mental healthcare. Although concerns were raised about patients with mental health issues staying in the A&E unnecessarily.
- A member of the mental health assessment team was present in the A&E department during the evenings as this was identified as the highest attendance period for this group of patients. This created improved working between this team and the nursing/medical staff for the benefit of these patients. We looked at the records of two patients with mental health needs. Both patients had been referred and seen by the mental health team.
- Patients identified as being alcohol dependent had been offered the opportunity to see the alcohol team. One patient who had used this service was now a volunteer.
- For patients with learning disabilities (LD) there was a LD nurse in addition to a link nurse. These patients may be known to the department and there will be a note alerting staff to their specific needs. In the same way patients with known allergies or who were violent will be flagged on the computer system so they could be managed appropriately.

Learning from complaints and concerns

- These were fed back individually to each person who was involved by either a band 7 nurse, ED manager or a consultant. Complaints, including trends, were fed back at the bi weekly clinical governance meetings. At handover any complaints were also discussed.

Are accident and emergency services well-led?

Good

Leadership of the department was good. All groups of staff said the culture of the department has changed for the better. Staff now have a voice and are confident they will be involved in any service changes and are proud of the care they give to patients. Staff are recognised by leaders for their hard work and are supported to do their jobs.

Vision and strategy for this service

- The trust has a mission statement; At Tameside Hospital 'Everyone Matters'. Our aim is to deliver, with our partners, safe, effective and personal care, which you can trust. Dignity, respect, trust and partnership are the themes which underpin their mission and values.
- Staff were confident that any changes made in the department would involve staff and patients.

Governance, risk management and quality measurement

- There was evidence of bi weekly clinical governance meeting at which incidents and complaints were discussed.
- There were weekly team briefs that were attended by all staff groups including doctors and porters.
- The care bundles were audited monthly.
- Performance meetings took place for band 7 and 6 nurses with the ED manager and matron on a weekly basis.
- There was a risk register that was discussed at the performance meetings.

Leadership of service

- A new matron covering A&E had recently been appointed. This had been well received.
- Shift leadership of the nursing staff was not visible. Several people were heard to say 'who is in charge?' in the vicinity of the majors board.
- We saw emails to staff praising them on their efforts for ensuring patients were treated in a timely way.
- The trust performed worse than expected in the 2013 General Medical Council National Training Scheme

Accident and emergency

Survey in the A&E department in overall satisfaction, clinical supervision, induction, receiving adequate experience, access to educational resources and receiving feedback.

Culture within the service

- We spoke to managers, doctors and nurses in the department all of whom said the 'culture' of the department has changed for the better, it is much more open and transparent and a nurse said 'staff are not afraid any more'. Ideas had been taken on board, for example, a staff nurse suggested changing the store room into an ambulance triage and this had been done, this greatly improved the patient flow, dignity and confidentiality as patients were no longer assessed in the corridor.
- Staff we spoke to said they were much happier in work and that there is improved leadership at the top and more visibility of those leading. A nurse who left the trust in 2009 has returned and said 'it was so much better', schemes are tested before implementation and the leaders are willing to change. All staff now had a voice and were supported to do their jobs.
- A volunteer and public governor said the trust was on an improvement journey, felt very passionate about the hospital and said that communication was getting much better.
- in the past managers were obsessed with targets and staff receiving telephone calls at home regarding breaches in target times was common practice.

Public and staff engagement

- There was a folder in the staff room highlighting the themes from complaints in addition to compliments. Communication was an area that patients do complain about.
  - We noted the Friends and Family Test feedback equipment was clearly visible on entering the department but not when patients left.

Medical care (including older people's care)

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

Information about the service

Medical care involves the assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Services included general medicine, respiratory, care of the elderly, gastroenterology, stroke, and diabetes across around 250 beds.

We visited the medical assessment and admissions unit (MAAU), and wards 5, 30, 31, 40, 43, 45, and 46. We spoke with, staff, relatives and patients. We observed interactions between staff and patients. We reviewed patient records and records relating to the management of the service.

Summary of findings

Some staff required greater understanding of the clinical management of deteriorating patients. admitted to their wards or units. They did not always adequately assess, monitor or manage risks to the patient or assess patients' needs or deliver care and treatment in line with current, standards, and national or internationally recognised evidence-based guidance.

Medical staff were concerned about the number of doctors available and the use of agency. Delays in consultant reviews were reported to us. Junior doctors told us of the number of shifts they worked.

Some patients experienced delays throughout their stay in hospital and were not always admitted to the right ward to meet their needs. The outcomes for patients, in some clinical areas, were poor compared to other services. This was mitigated somewhat by shared learning among clinical staff and the presence of cross-cutting staff, such as the outreach team and specialist nurses.

The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations. This had a positive impact on patient experience. Most people spoke positively about their recent experiences at the hospital, giving examples of how staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment.

Medical care (including older people's care)

The trust's governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks within the service. These arrangements were still very new, but the trust's track record on safety was improving. The trust had taken steps to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment.

Are medical care services safe?

Inadequate

Staff did not always adequately assess, monitor or manage risks to the patient. Some staff did not manage care or treatment, such as medications, in a safe way. Patients did not have timely access to assessments by relevant medical professionals. Some wards did not have enough staff to safely meet people's needs.

The trust's track record on safety was improving. The trust learned when things went wrong and improved safety standards as a result, although more work was needed to ensure staff reported incidents. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.

Incidents

- A new electronic system for reporting incidents had been recently introduced, replacing the paper-based tool.
- The trust had systems in place to report and monitor incidents including near misses, incidents that resulted in harm, Never Events (serious harm that is largely preventable) and allegations of abuse. Staff used the trust's electronic reporting system to report incidents; the trust collated this information and fed back to senior staff any trends or ongoing concerns so that improvements could be made. There have been no 'never events' in the service in the last 12 months.
- Staff said they received relevant feedback from incidents at ward meetings and at handovers. They said this process had improved in the last few months. Senior staff said they attended weekly meetings, which included representatives from the trust's risk team, to review all recorded incidents and take forward improvements.
- The trust reported 5,906 incidents between 1 February 2013 to 31 January 2014. This was higher than the expected number of incidents for a hospital of this type. Of those incidents, 940 resulted in harm and 13 resulted in death or severe harm.
- In the most recent NRLS report, the trust was the third highest reporter of incidents in small acute

organisations. The trust has stated their aim to improve the incident reporting rate whilst reducing level of harm. This indicates this is improving. The trust has lead a programme to improve incident reporting.

- The trust had a system in place to promote reporting of incidents, including 'trigger lists' developed for each area, in consultation with clinical teams. Medical services was part of the emergency and critical care division, which reported a total of 507 incidents in March 2014; 358 were incidents involving patients, most of which were specimen errors (as a safety improvement initiative) or slips/trips/falls.
- Individual patient records included evidence of incidents, most of which had been reported by staff. Where staff did report incidents, they were able to demonstrate the actions they took to reduce the risk of recurrence, such as corrections to the nutrition board beside a patient's bed.
- The trust had only just started to monitor and analyse reporting levels by staff type and location. Senior managers explained that medical staff were less likely to report incidents.

Safety thermometer

- The trust measured key indicators to provide assurance that patients were not harmed while receiving care in hospital. In March 2013, the medical care Safety Thermometer showed that 86.35% received 'no harm' from care. By March 2014 this improved to 98.93%, which surpassed the national and trust target of 95%.
- The percentage of patients who developed venous thromboembolism (VTE), or blood clots, was consistently below the trust target of 5% of all admitted patients.
- The percentage of patients who developed pressure ulcers in hospital was consistently below 1% of all admitted patients. The trust's target was to have no more than 5% of all admitted patients develop pressure ulcers.
- The percentage of patients who had an inpatient fall resulting in harm was consistently below both the trust target of 5% and the national average of 1% of all admitted patients.
- The percentage of patients who contracted a new catheter or urinary tract infection consistently matched national averages.

Cleanliness, infection control and hygiene

- Prior to the inspection, people raised concerns about poor infection control, such as clinicians not washing hands or staff leaving patients' catheter bags on the floor. However, we did not observe this during the inspection.
- The wards and departments were clean, tidy and free from unpleasant odours.
- Staff had access to disposable aprons, disposable gloves and antibacterial gel as well as liquid soap, paper hand towels and hand wash basins.
- Staff washed their hands following care interventions and on entering and leaving the wards and departments.
- The cleaning staff followed detailed plans and schedules so there was a plan of what needed to be cleaned and when. The schedule included when items and rooms should be 'deep cleaned'.
- Some patients were nursed in side rooms, to prevent cross-infection. We observed nurses correctly following protocols for isolation and barrier nursing, by nursing patients in side rooms and wearing protective clothing. However, on one occasion, a patient who was GDH positive (glutamate dehydrogenase positive, the germ responsible for Clostridium difficile) tried to entered the ward toilets. The staff correctly intervened and managed to stop the patient and take them back to the side room to use a commode.
- Patients commented that they always found the hospital to be clean and tidy and they had no concerns. One person on the MAAU said "staff always wash their hands before treatment" another said, "They cleaned the ward this morning and changed the bed linen. They did a thorough clean. The toilets are also clean and don't smell".
- When asked for positive feedback about the trust, the junior doctors commented that the hospital was "cleaner" than it used to be. Junior nurses said that staff have improved their hand-washing techniques.
- Audits and checks by the trust found that staff followed appropriate infection control guidance; however, these audits and checks did not include all relevant areas of the hospital.
- The trust had reported 50 cases of C. difficile in 2013/14. This was significantly higher than the expected number of cases (35) for their hospital.

- The trust had reported five cases of MRSA in 2013/14. This was higher than the expected number of cases (two) for their hospital. We noted that some of the cases were unavoidable (as identified through a root cause analysis undertaken with commissioners).

Environment and equipment

- Many wards and departments had been refurbished. Some wards were in need of decoration and repair. Staff said that the trust had planned refurbishment of some wards.
- Staff had access to equipment such as alternating air mattresses and cushions for patients identified as being at high risk of developing pressure sores.
- Staff had recently checked the resuscitation trolleys on wards 44 and 46 and replaced equipment when necessary. However, trolleys in other areas, such as the MAAU, had gaps in the records which indicated they were not checked daily or after emergency use. Staff confirmed they should be checked daily and after emergency use.
- The MAAU defibrillator checks did not include all relevant printouts or identify which trolley the checks were for.
- In our unannounced site visit on 17 May 2014, the resuscitation trolley in the MAAU had not received consistent daily checks in the weeks since our visits on 7 and 8 May 2014. The trolley was cluttered and the plastic wrap covering the drawers was pulled away, despite having had a recent check. This meant that staff could not be assured that the resuscitation trolley was fully stocked for emergency use.

Medicines

- Prior to the inspection, we received complaints about delays in receiving medications on the MAAU.
- During our site visit, one patient on the MAAU said that they requested medication for their long-term health condition, which needed to be taken at certain times of the day, and only received it several hours later. This patient's medication records did not reflect this delay but instead stated that the patient refused the medication. This meant that staff did not maintain accurate records of medication administration.
- One patient was prescribed an antipsychotic drug to be given as required (PRN) without clear guidance on its use. Antipsychotics, also known as neuroleptics or major tranquilisers, are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought). This meant that medical staff had not provided PRN guidance to ensure that staff administered the antipsychotic medication safely.
- A patient's treatment sheet on MAAU indicated that, on two separate occasions, a controlled medication had not been administered as prescribed. The controlled drugs record confirmed it had not been given.
- Staff prescribed another patient in the MAAU an unsuitable dose of a sedative medication. This dose did not take the patient's weight and height into account. This resulted in the patient receiving medication to counteract the sedative side effects. This was identified as an issue and promptly dealt with by the trust.
- Medication records on the MAAU were not completed fully by staff. Two patients' prescriptions, which included controlled medications, had not been signed for by a prescribing clinician.
- There is a safety thermometer for medicines in use to allow the service to take an overview of issues.
- Between 1 April and 9 May 2014, staff reported only seven incidents relating to medication in respect of the MHDU/CCU, MAAU and intensive therapy unit (ITU). This suggested that there may be under-reporting of medication errors in these areas.

Records

- We looked at the records for 19 patients. The nursing notes contained completed assessments of patients' needs and risks, including patient moving and handling, the malnutrition universal screening tool, pressure ulcer development (the Waterlow risk assessment) and risk of falls. Patients also had specific assessments relevant to their condition, such as mental health, occupational therapy and physiotherapy.
- Staff followed a pre-admission procedure, including initial assessments of people's individual needs. Care plans were developed according to people's needs and included assessments in people's mental health, medical needs, nutrition, continence, personal care, mobility, orientation and social skills. Each file included people's wishes regarding resuscitation and end of life where relevant.
- In some areas of the hospital, staff used pressure-relieving mattresses appropriately for patients at risk of pressure ulcers. One patient, who had several pressure ulcers and required assistance to move, had position charts which showed they had been helped to

roll over in bed at 9.50am with no further assistance documented. At 12pm, this patient was sitting out of bed. This omission to record positional changes could mean that patients were not helped as required to reduce the risk of pressure ulcers developing or to minimise the danger of a patient's condition deteriorating.

- In most wards, staff regularly weighed patients as instructed by doctors. Some patients' records showed gaps which did not have any written explanation. In some cases, staff did not know whether the patient had been weighed or not. In other cases, staff knew but did not record the reason.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had systems and procedures in place with regard to mental health assessments under the Mental Capacity Act 2005 for people who lacked capacity. The Act aims to empower and protect people who may not be able to make some decisions for themselves.
- Patient records showed capacity assessments and consultation with relatives, friends or advocates where necessary. These records showed that staff had acted in people's best interest and that people's human rights were not compromised.
- Several deprivation of liberty safeguards assessments had been completed for patients at the hospital in 2014. These assessments ensured that people's human rights were protected by requiring staff to assess and record any restrictions to liberty (i.e. restrictions in movement).
- Staff said they had training in mental capacity and the related deprivation of liberty safeguards.

Safeguarding

- The trust had appropriate procedures in place to support staff to identify and report allegations of abuse. Most staff knew what the types of abuse were and how to report allegations.
- In the January inspection, we raised concerns with the trust that staff could not adequately identify the risks of abuse to patients in hospitals. In this inspection, junior nurses were able to identify signs of abuse.
- Staff reported concerns directly to the safeguarding lead for the trust.
- Each ward had a performance dashboard that showed that most wards were compliant with the trust's target for the percentage of staff completing safeguarding vulnerable adults training (95%).
- In the January 2014 inspection, we raised concerns with the trust that staff did not adequately manage patients with challenging behaviour. In this inspection, staff still did not always appear to use or refer to the trust policy on caring for people who exhibit specific behaviours which may challenge or cause injury to themselves or others. Although staff recorded behaviours as a chronology of events, they did not analyse behaviour or develop robust care plans that identified known 'triggers' and strategies. Some staff still used sedative medication as a form of restraint without maintaining an adequate record of this decision-making.
- The Trust has developed a training competency framework. Data show training is on-going.
- The Trust also use a weekly dashboard and tracking systems.

Mandatory training

- The trust ward-based data for January 2014 showed that the percentage of staff who had attended mandatory training fell below trust target (95%) for many medical wards. The percentage of ward staff who had completed various mandatory training ranged from 72% (ward 45) to 100% (ward 44).
- The overall trust data for February 2014 showed that 83% staff had completed the staff workbook, 87% had completed manual handling training, and 90% had completed resuscitation training. This fell below the trust target of 95%.

Assessing and responding to patient risk

- Some patients were missing key assessments, such as for VTE.
- Nurses recorded observations and calculated a patient at risk score (PARS), which they used to identify deteriorating patients. Increased PARS triggered more frequent observations or prompt escalation to medical staff.
- Junior doctors raised concerns about nurses not following the trust's escalation policy, such as calling junior doctors for a deteriorating patient when the patient's PARS indicated the nurses should have called the specialist registrar.
- Doctors also raised concerns about nurses managing patients on their own rather than seeking medical advice. They believed this was due to some nurses' "fear of disturbing" the already busy or unavailable doctor.

Medical care (including older people's care)

- The National Institute for Health and Care Excellence (NICE) clinical guidance (CG 50) for acutely ill patients in hospital states that all patients admitted to the MAAU should have an initial assessment of their severity and risk.
- The MAAU's audit showed that in January, February and March 2014, the percentage of patients who had an initial assessment within 15 minutes of admission to the ward was 35%, 71% and 43%, respectively.
- The hospital episode statistics data for 1 December 2012 to 30 November 2013 indicated an increased risk of death for patients admitted as an emergency and with a primary diagnosis matched to either a cardiological or a neurological clinical classification software diagnosis group. This meant that more people than expected, with a primary diagnoses contained in these two groups, died at this hospital.
- Patients with serious heart conditions, such as ST segment elevation myocardial infarction, were immediately referred and transferred to a specialist hospital via ambulance.

Nursing staffing

- A senior manager stated that the trust assessed nursing numbers using the Association of UK University Hospitals (AUKUH) Acuity/Dependency tool and that the trust undertook a patient and dependency review every six months.
- The trust expected ward managers to undertake 50% of their time working clinically. They were considered supernumerary to the establishment.
- The nursing rotas showed that at least one shift had only one substantive nurse allocated to the ward. This was because the trust had a high level of nursing vacancies on the medical wards. This meant that wards needed agency nurses to achieve safe staffing levels.
- The Trust had identified a shortfall in the nursing establishment and were actively recruiting to these posts. The trust had a plan in place to recruit more nurses, including inducting a cohort of nurses from another European country in May 2014. We spoke with the nurses, who had just arrived in England. They said they were excited to start their new posts.
- Staff had mixed opinions about whether there was enough staff. Out of the 29 reported incidents in March 2014 relating to staff, 23 were about a lack of nursing staff. Most of the 29 incidents were reported by staff on medical wards.
- Where possible, the same agency staff were used for longer periods. But sometimes agency nurses did not show up for their shifts on time or at all. Some bank nurses were nurses who held substantive posts at the trust, taking on additional shifts. The usage of agency nurses made it more difficult for ward managers to ensure that the team had an adequate mix of skills to meet people's needs.
- The trust had systems in place to ensure that additional staff were available should the ward manager request one-to-one support for any patient.
- The MAAU nursing team did not have the appropriate skills mix to care for the range of patients who were admitted to the unit, which regularly included surgical or specialist medical patients.
- Most cardiology patients were eventually transferred to a specialist cardiology ward as per good practice; however, the staffing levels on this ward did not always reflect the acuity of the patients. This meant that staff on this ward did not have enough time to practice the specialist skills required for caring for cardiology patients such as fluid balance and urine weighing. The trust does however use a nursing acuity tool.
- The trust has however made improvements in its nurse staffing, including nurse ratios and skill mix.

Medical staffing

- Doctors were concerned about the inadequate number of doctors. The trust had a number of vacancies which they have struggled to fill. This resulted in the trust using locum doctors to achieve safe staffing levels. The trust had a plan in place to recruit doctors.
- Medical doctors shared a rota for on-call coverage out of hours (weekends and nights). This meant that sometimes there were delays in consultants' reviews of patients with specialist needs, such as cardiology or renal function.
- Junior doctors welcomed the extra specialist registrar on the weekend, but said that this doctor also held the foundation year one bleep in the morning so could not provide adequate supervision during this time. This was however largely seen as a positive action.
- Doctors raised concerns about how the trust planned and managed the medical rota; they said that they regularly worked a high number of shifts or were on call with insufficient breaks in between. Doctors of all grades were concerned that the rota sometimes left teams without a junior doctor.

Medical care (including older people's care)

- The junior doctors spoke positively about the addition of a twilight shift to deal with busy times. However, the trust did not have an adequate staffing plan in place to cope with busy periods, such as last-minute staff absences or suddenly increased number of deteriorating patients. This led to inconsistencies on how teams managed busy periods.

Major incident awareness and training

- The trust had an escalation policy to accommodate winter pressure. Staff noted that winter 2014 was much more mild than the previous winter, which resulted in decreased need for escalation areas.
- The trust is working with health economy partners on an admission avoidance programme to reduce pressures further in future years.
- The trust had a policy which outlined planned actions in the unlikely event that the wards required closure.
- Staff said they would follow the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.

Are medical care services effective?

Requires improvement

Staff did not always assess patients' needs or deliver care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. The outcomes for patients, in some clinical areas, were poor compared to other services. There were poor care plans for stroke patients.

The trust had taken steps to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment. However, staff did not have the necessary competencies to treat patients admitted to their wards or units. This was mitigated somewhat by shared learning among staff and the presence of cross-cutting staff, such as the outreach team and specialist nurses.

The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations.

Evidence-based care and treatment

- One patient with diabetes was admitted to the MAAU after their elective pacing procedure. Their records did not indicate that they had diabetes; they did not have a care plan for managing their diabetes nor was their blood glucose monitored.
- Staff followed national stroke pathways, such as admitting patients straight from A&E to the short stay stroke unit for assessments.
- Staff responded to one patient on the general medical wards who complained of new chest pain. Staff called a doctor and performed an echocardiogram to identify the need for further assessments or treatments. The night nurse practitioner reviewed the patient in the evening to ensure the patient received adequate care.
- There were pre-printed care plans inserted in the patients' records when an assessment of need had identified that specific care was required. These included plans for nutrition and hydration, meeting hygiene needs and specific interventions such as stoma care. These care plans had blank spaces where staff needed to insert information to personalise the care plans to the individual. Some care plans had not been personalised.
- Some patients were missing key care plans to manage their specific interventions, such as oxygen treatment, wound care, or catheter care.

Pain relief

- Three patient records did not include pain management care plans, despite staff completing assessments which indicated the patients were in pain.

Nutrition and hydration

- Prior to the inspection, people raised concerns about the unsafe provision of food supplements and drink thickeners on the stroke unit. However, we did not observe this during the inspection.
- People also raised concerns about inadequate support during mealtimes in the MAAU. They felt this was due to lack of staffing. The trust was in the process of implementing a volunteer programme to provide patients with additional companionship and support during mealtimes.
- Information about patients' diet and nutrition was written in patient records or on boards above their bed. On the wards, staff provided support to those who needed additional help. Sometimes this included special equipment.

- Staff did not consistently record the actions taken as a result of weight loss or excessive rapid gain. Where actions had been taken, for example, the prescribing of food supplements, staff had not adequately recorded the monitoring of the effectiveness of these actions.

Patient outcomes

- In February 2014, the percentage of people on medical wards who recommended the service in the Friends and Family Test ranged from 55% to 100%.
- In 2013/14, the trust participated in all eligible audits.
- The Royal College of Physicians' Stroke Improvement National Audit Programme scored the trust as 'E' for domain 2, which looked at key indicators for stroke unit performance. This meant that the hospital's stroke unit performed significantly worse than expected. The college based this assessment on stroke patients admitted to and/or discharged from the hospital between October and December 2013.
- The National Institute for Cardiovascular Outcomes Research (NICOR) Myocardial Ischaemia National Audit Project showed that the proportion of patients who received all secondary prevention medications for which they were eligible (86%) was similar to expected (90%) for this hospital.
- The trust failed to meet national targets for scanning stroke patients within one hour, although they met national targets for the 12-hour scans.
- From April 2013 to January 2014, only an average of 64% of patients were admitted to a stroke bed within four hours of arrival or admission. This failed to meet the trust target of 80%.
- From April 2013 to February 2014, only an average of 18% of the high risk patients were seen by a stroke consultant within 24 hours of admission. This failed to meet the national target (58.1%).
- The trust's non-elective re-admission (within 30 days) rate was around 15%. This is consistent with other organisations.

Competent staff

- During the report period May 2013 to February 2014 the trust reported that 81.44% of staff had completed their performance development review in May 2013. In February 2014 this was reported as 78.80%, which was below trust targets.
- Staff worked together to share knowledge. The trust recently appointed specialist nurses to promote high-quality care across the trust. Staff from the stroke wards trained other ward staff in completing stroke assessments. Staff spoke positively about accessing support from the trust's outreach team when caring for deteriorating patients.
- Staff in many wards said they received "frequent" supervision from their line manager and annual appraisals. Nurses said they felt well-supported by their line managers and other senior staff, saying "there is always someone to ask".
- On the MAAU and Ward 45, however, some staff had not had regular supervisions or a recent appraisal. The unit and ward managers were aware of this gap and hoped the increase in band 6 nurses would give them time to complete more appraisals.
- Clinical staff on the MAAU and MHDU/CCU did not demonstrate adequate understanding of treating deteriorating cardiology patients. This meant that staff had not identified patients as needing specialist urgent care and patients did not promptly access the investigations and treatment they needed.
- Although they said weekly training was good, junior doctors said that teaching was "non-existent" on ward rounds. It was difficult for doctors to arrange ward cover to attend the weekly training.

Multidisciplinary working

- During handover on one ward, a multidisciplinary team comprised of a social worker, occupational therapist and nurses, reviewed each patient's discharge planning to facilitate access to social care support.
- Staff referred patients to physiotherapists, mental health services, social workers, dieticians, and speech and language therapists.
- Junior doctors said that patients had good access to radiology.
- Junior nurses said that trust recently improved access to pharmacists.
- The trust had a stroke response team that was available from 7am to 8pm, Monday to Friday. Senior managers chaired a monthly trust-wide stroke group meeting which included patient representatives, representatives from a national charity, and commissioners. The multidisciplinary stroke rehabilitation team also met monthly.

Seven-day services

- Pharmacists were now available seven days a week, although the small number of staff on duty on the

weekend limited the pharmacy team's activities during this time. Many patients admitted on Friday or over the weekend still experienced delays in having their medicines reviewed by a pharmacist.
- The hospital increased middle-grade medical cover over the weekend. Staff did not feel this was adequate to manage the medical admissions.
- Doctors raised concerns about the lack of support from senior doctors out of hours. Most doctors stated that this depended on who was on call, as specific senior doctors provided poor-quality supervision and guidance compared to others. One doctor said this was due to their reluctance to contact a senior doctor out of hours, out of empathy for the senior doctor who was working a shift the next day. Other doctors cited a lack of senior staff in post.

Are medical care services caring?

Good

Most people spoke positively about their recent experiences at the hospital, giving examples of how staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust involved people who used the service and those close to them as 'partners' in their care and treatment.

The friends and family test was consistently above the national average.

The trust had improved how it supported people to make informed decisions, although some work was needed to ensure patients and those close to them received the information relevant to their care and treatment. Staff provided patients and relatives/carers the support they needed to cope emotionally with the care and treatment.

Compassionate care

- Staff interacted positively with patients during the delivery of patient care and when supporting patients during mealtimes.
- Patients appeared comfortable and settled. Most were complimentary about the care they received.
- On some wards, patients knew which staff were on duty and called them by name. On other wards, however, some staff did not have visible name badges and did not introduce themselves to patients. This meant that people did not know what to call staff when they had a question or needed help.
- One patient's relative said, "The care of my [relative] here has been fantastic and staff have looked after [them] really well." One patient said, "I am well looked after. I have been given support to eat, and help from a physiotherapist."
- Three patients were happy with the care they had received on the MAAU. Two out of the three patients were also happy with the care they had received. One patient said "I have been very happy with the quality of the care".
- Patients said staff attended to them quickly if they needed assistance.
- One patient said the care they received was "extremely good", that they "get lots of attention" from staff, and staff communicated with them regularly.
- "My mother is really well looked after, her needs have increased and everyone is doing what is needed to adjust to her needs and make sure she is comfortable".
- Another relative said, "The care is excellent here, we could not wish for better care".
- Most staff respected patient dignity when providing care or during transfers to other areas, by closing doors, drawing curtains, or covering with bed sheets. In one ward, however, an agency staff member assisted a patient in physiotherapy exercises with the door open, which left the patient exposed to the ward.
- The friends and family test was consistently above the national average.

Patient understanding and involvement

- We observed staff explaining to patients as they administered medications.
- One relative said they were happy because the doctors explained the illness in terms they could understand.
- On the MAAU, two patients said they were happy with the support they had received from the doctors and nurses. One patient said staff had not kept them informed about what was happening. Another patient said they did not know when they would be discharged.
- One person said "I feel safe here because there is always staff here who are able to help me, they always ask first". Another patient said " Both medical and care staff seem to know what they are doing and communicate effectively with me and involve me in my care".

Medical care (including older people's care)

- Some wards displayed information about dementia on their noticeboards.

Emotional support

- The trust had a chaplaincy which was multicultural and this could be accessed to provide emotional and spiritual support for the patient and families.
- One patient's relative said: "There is always someone you can talk to."
- Representatives from a national charity visited the stroke unit once a week to lead social events and to support patients and relatives.

Are medical care services responsive?

Requires improvement

The trust did not plan or deliver its services to meet the needs of different people. The trust did not take adequate steps to ensure that people accessed its services in a timely way.

Although the trust demonstrated improvements, staff still did not take account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge and at transitions. However, the trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- The trust had recently increased the bed management team to cover nights, which would free up night nurse practitioners to supervise clinical care instead of managing beds.
- Nurses raised concerns about patients returning to the MAAU from the wards to access telemetry or non-invasive ventilation because no beds were available on the MHDU/CCU or respiratory ward.
- The trust had only just started to monitor the number of patients who transferred back to the MAAU. During our inspection visit, three patients had returned to the MAAU to access specialist treatment.
- Junior doctors raised concerns about "poor productivity" on the wards. On one occasion in the MAAU, we observed staff spent 30 minutes chatting with each other rather than attending to patients. This time could have been spent attending to patients' individual needs.

Access and flow

- Patients were admitted to wards through the A&E or MAAU. Patients referred to the hospital by their GPs waited in the A&E until a bed was ready for them on the MAAU.
- There were 4 surgical beds on the MAAU; however, doctors raised concerns about inappropriate referrals from A&E; this resulted in surgical patients being admitted to the MAAU and experiencing delays in accessing necessary assessments or treatments. There was a perception amongst some staff who felt that this was to get patients out of the A&E before they breached the 4-hour waiting time target. Staff in the MAAU said they assessed all patients and tried to redirect them to the correct team for treatment.
- Following emergency admission, patients in the MAAU waited in chairs or on trolleys as bed spaces were not available. Three staff commented that this was becoming a regular occurrence.
- The business managers were aware of the problems with capacity. The trust had an escalation policy in place, which included liaising with local commissioners to improve capacity.
- The trust reported that the MAAU admissions were around 1350 per month in the last year, with 61% transferred to another ward in the hospital and 39% discharged. Of the discharged patients, 40% were on the MAAU for up to 12 hours, 36% were there for 12 to 24 hours, and 24% were on the MAAU for over 24 hours.
- On one ward, six patients were deemed medically fit for discharge but waited on social care assessments. Staff on this ward said that there were "usually" six to 10 patients awaiting discharge, which was a significant proportion of patients on that ward.
- A range of staff consistently raised concerns about discharge planning within the local community. These concerns included: lack of beds in intermediate care facilities or care homes and limits on the number of social care placements funded each week.
- Junior nurses stated that doctors were unavailable to complete discharge processes for a significant part of

the day due to morning medical rounds and lunch. This meant that the trust had an increased backlog of patients awaiting discharge, which doctors started to address at 2pm.
- Junior doctors raised concerns about the lack of robust bed management, saying that patients got "lost" in the system. However, there were no medical outliers at the time of our visit. Although staff maintained records of the number and location of outliers, in their capacity reports, these records were not in a format that could be easily analysed or audited.

Meeting people's individual needs

- The trust had link nurses for specialist conditions, such as dementia or diabetes.
- Staff demonstrated that they understood how to support patients with challenging behaviour in a person-centred way. However, they did not follow written guidance or a behavioural management plans. This resulted in inconsistencies in how staff managed challenging behaviour.
- Staff raised concerns that patients requiring care for psychiatric conditions did not receive adequate medical care before being transferred to the local mental health provider.
- Staff had access to interpreter and translation services. Staff on the stroke unit described how the service was able to accommodate specific dialects, to meet the needs of individual patients and people close to them.
- The trust had an outside garden area which was dementia-friendly.
- Some wards did not have adequate plans in place to help them meet the needs of patients living with dementia.
- Some wards did not have a prompt for staff to identify patients living with dementia. Staff said that this information would be covered during handover of patients.
- The stroke ward had leaflets explaining stroke care and promoting local support groups. Patient records on the stroke ward evidenced meetings between families and consultants. Patients also had communication records which detailed conversations between families and staff
- For one patient at the end of their life, their "this is me" booklet, which was designed to give staff the information they need for patients living with dementia, was blank. This meant staff may not have had all the information they required to understand the patient's communication, behaviour, wishes and needs.
- On one ward, staff said they felt they could not always adequately meet the needs of people living with dementia at the end of their lives. They said this was due to low staffing numbers which meant they did not have enough time to spend with patients with additional needs.

Learning from complaints and concerns

- Ward managers had responsibility for receiving complaints and ensuring staff learned from them. On one ward, the manager was on leave, so a matron managed complaints in their absence.
- Staff said they received feedback from incidents or updated policies via team meetings and individual emails.
- The complaints manager said that they received fewer 'come-back' letters since they started personalising letters to complainants.
- At the last inspection, we raised concerns about how the trust supported staff to manage complaints. The trust was now in the process of developing a complaints resolution meeting toolkit. This meant that the trust took action on concerns we raised in the last inspection, to support front-line staff to learn from complaints and concerns.
- The trust's review of the Patient Advice and Liaison Service (PALS) and complaints between April 2013 and March 2014 stated the top three primary subjects of complaints were concerns relating to medical rather than nursing care.

Are medical care services well-led?

Requires improvement

There were clear issues within the service that required addressing in process and practice. In some areas there were challenges with delivering improvements. Whilst some staff were happy working in medical care services; others were less happy. Turnover of staff was higher than other areas.

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for

people. The governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks. These arrangements, however, were still very new, and the trust was not yet able to demonstrate whether the systems were robust enough to ensure high-quality and safe care.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The trust engaged well with people who used the service, public and staff, seeking and acting on their feedback. The challenging workloads had a negative impact on staff experience.

Vision and strategy for this service

- Public areas of the hospital had been recently renovated to promote the trust's vision.
- Staff spoke positively about the changes and said they were committed to improving the trust.
- The trust had recently developed a new clinical audit strategy. Staff in the governance team had a clear plan for implementing this strategy throughout the trust.

Governance, risk management and quality measurement

- Records demonstrated that, when staff reported incidents, they learned from the investigations that took place. Notices in the staff room and monthly team meetings helped staff to implement appropriate changes.
- Two ward managers said that they carried out regular audits and checks on things such as hand washing and completion of patient records. These wards had an agreed action plan to address issues and concerns. Managers allocated action points to staff, with clear time indicators for completion.
- Wards participated in an external accreditation programme which resulted in action plans.
- Following a robust review of their clinical effectiveness programme, the trust re-designed and re-launched a new system for managing clinical audits, as part of wider governance changes. They had not yet completed full cycles of their audits. Initial feedback from the medical staff was positive.
- The trust received four regulation 28: report to prevent future deaths (rule 43) letters from the coroner dated January 2014 and March 2014. Although the trust responded to these formally, we observed that staff had not yet fully implemented all the changes into their practice.

Leadership of service

- The trust recently made significant changes to the leadership of the service, such as appointing a new clinical director and ward managers. The stroke ward had a new grade 7 nurse.
- Each ward had a named senior person in charge of each shift.
- A relative said, "The [ward] manager and staff are very approachable, we can discuss any concerns".
- Staff and members of the public both raised concerns about the proportion of supernumerary time that ward managers had, stating this resulted in a build-up of paperwork because the ward managers were busy providing clinical care to patients.
- It was noted that ward managers are expected to spend 50% of their time working clinically, and 50% managerially. They were supernumerary to the staffing establishment.
- Nurses on the MAAU stated that they felt supported by their line manager, who was "approachable".
- Several ward managers were new to their post, having been recently promoted to their first leadership position. They spoke enthusiastically about their new role and identified changes they made to the wards, such as documented multidisciplinary ward rounds. Staff on these wards spoke positively about the new managers.
- Ward staff were enrolled in a leadership development programme.
- Some managers struggled to identify and manage poor-quality care.
- Junior doctors raised concerns about the leadership, stating the current provision of medical care was not optimised for training junior doctors, as specialist registrars had no "ownership".

Culture within the service

- We observed positive interactions between senior and junior nurses on the wards.
- One doctor said they were counting the days to when they left as the workload was heavy and the stress had triggered negative physical side effects.
- One cleaner said they "love working on the ward."

Medical care (including older people's care)

- Junior doctors stated this was a friendly, small hospital "where you know people" and "consultants recognise you." Most said they would recommend working at the trust; however, many said they would hesitate to return for more training. They said the hospital had a bad reputation amongst trainee doctors and doctors did not discuss in a positive light when they were assigned to train there.
- Staff spoke negatively about how wards worked with other wards, stating that it was not team-based and was "bad for training".
- Doctors and nurses both said they remained concerned after going home about issues within the service. One junior doctor said "Will the next doctor remember the jobs I gave them?" citing the huge workloads people shared.

Public and staff engagement

- The trust had comments boxes throughout the hospital, inviting people to comment on whether they would recommend the trust to their friends and family.
- The trust appointed more staff to lead on patient engagement and recently completed an engagement programme called "Tameside Listens".
- The trust welcomed visits by patient groups, such as Healthwatch or Tameside Hospital Action Group, to see for themselves how the hospital was performing. The Tameside Hospital Action Group produced a report in May 2014 as a result of multiple site visits to medical wards earlier in 2014.
- Nurses on the MAAU said that their concerns were now being listened to and addressed, such as increased staffing of band 6 rather than band 5 nurses, to improve the skills mix.
- A chaplain explained that staff requested a dedicated prayer space and, as a result, the trust planned to develop a larger chapel.

Surgery

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

Information about the service

The hospital had 84 surgical beds located in the trauma, elective and surgical units. The units provided a range of surgical services including general surgery, ear, nose and throat (ENT) surgery, trauma care and orthopaedics. In addition, the hospital had 12 inpatient beds and six day-case beds located within the women's health unit. The hospital had a dedicated endoscopy service and theatres with anaesthetic and recovery facilities.

During the inspection, we visited the trauma, elective and surgical units, the women's health unit, the endoscopy unit and theatres. We spoke with 30 patients and relatives and 68 members of staff, including consultants, registrars, junior doctors, matrons, ward managers, general managers, specialist nurses, staff nurses, healthcare assistants, physiotherapists, pharmacists, occupational therapists and domestic staff.

Summary of findings

People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust took steps to engage with people who used the service, public and staff, however, more work was needed to ensure that people had all relevant information and that the trust received and acted on their feedback. Many staff were clear about their responsibilities and identified, understood and managed risks, but the trust did not yet have an embedded system in place to ensure that all staff regularly considered quality and performance (e.g. with patient flow). Patient access to surgery was limited by hospital capacity; this resulted in last-minute changes to the theatre lists. Patient flow was sometimes disorganised, resulting in poor patient experience of the service.

The trust's track record on safety demonstrated improvements. Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. Staff followed a robust infection control policy and used well-equipped decontamination facilities. The trust learned when things went wrong and improved safety standards as a result, although more work was needed to ensure staff reported incidents appropriately. The patient-reported outcomes (PROMS) for people using the service were good, with exception of knee and hip surgery, which were poor compared to other hospitals.

Surgery

Are surgery services safe?

Requires improvement

The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. Potential risks to the service were anticipated and planned for in advance. Most staff had attended mandatory training. There were some staff vacancies which resulted in less support available for junior doctors in certain specialties.

The trust's track record on safety demonstrated improvements. Staff followed a robust infection control policy and used well-equipped decontamination facilities. The trust learned when things went wrong and improved safety standards as a result, although more work was needed to ensure staff reported incidents appropriately. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.

Incidents

- There were no Never Events (serious harm that is largely preventable) between January 2013 and December 2013 within elective services.
- Between March 2013 and February 2014, surgical specialities accounted for 10% of the incidents reported to the National Reporting and Learning System by the trust; almost all (13/14) were of the less significant moderate harm rather than a more significant category.
- Staff carried out full root cause analyses on all serious incidents and discussed themes from incidents at ward meetings.
- Staff stated they knew how to report incidents and said managers encouraged them to report all incidents. Those who reported incidents received feedback via email and, if necessary, from a manager.

Safety thermometer

- The trust displayed Safety Thermometer information at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), or blood clots, catheter use with urinary tract infections and new pressure ulcers.
- This information showed that the trust consistently reduced the percentage of patients who experienced harm such as new pressure ulcers. By March 2014, the percentage for five categories was consistently below the national average.

Cleanliness, infection control and hygiene

- Ward areas appeared clean. There was enough personal protective equipment such as gloves and aprons located outside all side rooms and bays.
- Staff regularly washed their hands, used hand gel between seeing patients and adhered to 'bare below the elbow' policies.
- Patients had access to isolation facilities. Staff knew the procedure to follow for patients who required isolation.
- Endoscopy had a fully tracked decontamination system, which meant that reusable equipment was numbered and its decontamination details were referenced in the patient's notes via that number.
- The infection control team members received alerts on any new potential outbreak in the trust. They investigated the source of the infection, increased surveillance of the outbreak, and worked alongside the multidisciplinary team to ensure staff provided appropriate care and treatment, such the most effective medication, to patients. The infection control lead told us the trust had recently appointed two full-time members of staff to assist with reducing the risk of cross-infection.
- The trust had introduced a pocket-sized information card for clinical staff to use; the card detailed appropriate antibiotic prophylaxis and treatment. Staff welcomed this initiative.

Environment and equipment

- Public and patient areas were clean, bright and welcoming.
- Staff checked and cleaned equipment, such as the resuscitation trolleys, regularly.

Medicines

- Staff stored medicines in locked cupboards or fridges. Records showed that staff checked fridge temperatures regularly.
- A ward pharmacist said they checked ward stocks of medicines and, when necessary, highlighted prescribing errors to doctors and reported the errors through the trust's incident reporting system.

Surgery

- Before the inspection, we received multiple concerns from the public about the management of pain relief medication. One person, whose relative had recently stayed on an elective surgery ward, confirmed that the pharmacists on the elective surgical wards had reviewed and signed off their relative's medication records. They raised concerns that the pharmacist had failed to identify and take action regarding gaps in the administration of pain relief medication. This meant that there may be an under-reporting of medication errors, as staff may not be adequately identifying errors.
- The controlled drug register confirmed there was a checking process in place.
- The ward manager carried out medication audits and fed back the results of the audit to staff via the ward meeting. A recent document produced by the matron ("matron's memo") outlined medicines management issues.
- Patients were weighed on admission. This meant that staff could use this information to prescribe appropriate dosages.
- Nursing staff were aware of the Nursing and Midwifery Council's Standards for Medicines Management, such as checking medications before administration.

Records

- Nursing records were in paper format and, when they were not in use, were kept in a locked room which had a keypad entry. Medical records were also kept in the same lockable facility.
- The trust had implemented a new electronic system for record keeping. Staff told us there were some implementation problems but things had improved.
- The ward managers undertook documentation audits and fed back results to staff via the matron's memo.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff provided appropriate information to patients about procedures. Patients who were able to had provided written consent to procedures.
- For patients who did not have capacity to consent to their procedure, staff applied the principles of the Mental Capacity Act 2005. Where relevant, staff applied deprivation of liberty safeguards.
- The trust had a policy on patients who lacked capacity (November 2012). Staff were aware of the policy and said they had access to specialist advice if required.
- Information cards on the Act and its associated deprivation of liberty safeguards were seen on the wards.

Safeguarding

- Staff had responded appropriately to safeguarding concerns by following trust procedures and involving other agencies.
- There was a safeguarding adults manager and a safeguarding lead in post.
- The safeguarding adults manager knew how to deal with a child safeguarding concern and gave an example of how they had referred a child who they perceived to be at risk.

Mandatory training

- An audit dated February 2014 on staff mandatory training confirmed that 92% of the surgical staff were up to date with their manual handling training and 89% were up to date with their resuscitation training. This was below the trust target of 95%.

Management of deteriorating patients

- The surgical wards used an early warning tool called patient at risk score (PARS). The trust had plans to implement a different early warning tool called the national early warning score (NEWS) system.
- A NEWS implementation paper dated 7 May 2014 noted the trust had established a multi-professional working group. The working group was responsible for facilitating the deployment and management of the NEWS system across the hospital. This group was also responsible for monitoring and ensuring compliance with the PARS system.
- A recent audit of PARS had demonstrated that staff had not performed or calculated patient observations correctly. Managers asked staff to ensure they improved practice before the implementation of the new escalation tool.
- Completed PARS charts showed that staff had escalated correctly when patients' conditions deteriorated and repeated observations within the recommended time frames.

Nursing staffing

- Each ward displayed planned and actual staffing numbers.
- Staff said they reported through the trust incident reporting system when the wards were understaffed.

- Staff said agency staff filled vacancies. This incurred significant cost to the trust. All agency staff were inducted locally on arrival for their shift.
- In a nursing handover on an evening to night shift, four nurses discussed staffing for the shift as well as high-risk patients or potential issues. Nursing handovers occurred twice a day.
- In the 2012/13 Cancer Patient Experience Survey, the trust performed worse than other trusts on the question: "Always/ nearly enough nurses on duty".

Medical staffing

- Surgical consultants from general surgery and orthopaedics were on call for 24-hour periods, seven days a week. ENT surgical cover was provided Monday – Friday, with patients transferred to another local hospital at weekends.
- A handover during the evening was consultant-led, structured and documented. Staff discussed patient admissions and action plans. The service maintained a record of attendance.
- Junior doctors said there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.

Major incident awareness and training

- A general manager said that there were plans in place for major incidents and that they were part of the major incident command structure.
- Staff explained there was an emergency planning officer employed within the trust who provided advice and guidance on major incident planning and business continuity management.
- There was a dedicated separate team for emergency theatre. Staff said they would defer elective activity in order to give adequate priority to unscheduled admissions. The trust had a theatre available for emergencies.

Are surgery services effective?

Requires improvement

Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. More work was needed to ensure staff fully implemented enhanced recovery programmes. For knee and hip surgery, the outcomes for people using the service were poor compared to other services.

The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations.

Evidence-based care and treatment

- Elective services used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons (RCS) guidelines to determine the treatment they provided. These included NICE guidelines on upper gastrointestinal bleeding and breast cancer. Staff wrote and updated local policies in line with changing national guidance.
- Staff utilised elements of the enhanced recovery programme but did not ensure that patients had clear fluids to drink up to two hours prior to surgery. Staff also did not use cardiac monitoring for intra-operative fluid management.
- Elective surgical staff used the World Health Organization (WHO) safety checklist in the operating theatre to confirm patient identity and the correct operation. They had worked to modify and adapt it to local circumstances as proposed by WHO.
- The Royal College of Physicians' National Hip Fracture Database showed that the proportion of cases assessed as compliant with all nine standards of care (56%) was similar to expected (60%) for this hospital.

Pain relief

- Staff assessed patients pre-operatively for post-operative pain relief.
- Prior to the inspection, we had received concerns about the management of pain relief. However, during the inspection, patients said they had adequate pain relief arrangements in place.
- Staff said they were trained in epidural and patient-controlled analgesia.
- Records confirmed that staff observed patients and documented patients' pain scores. Records also showed evidence of intentional rounding which meant patients were assessed and evaluated at specific times.

- There was a dedicated pain team within the trust and staff knew how to contact them for advice and treatment when required.

Nutrition and hydration

- Staff used the malnutrition universal screening tool to identify patients at risk of malnutrition. Patient records showed that staff completed these tools accurately and fully.
- One volunteer said their job was to help patients with eating and drinking. During the inspection, we observed that staff gave out drinks and placed fluids within patients' reach.
- Patients had access to special diets which met their individual needs.

Patient outcomes

- In 2013/14, the trust participated in all national surgery related clinical audits, as detailed in their annual quality report.
- Although the trust recorded the surgical outliers during their bed management meetings so that staff are aware of patients' locations, the trust did not maintain records that were centrally collated or usable for analysis of this monitoring in such a way that the numbers and trends of outliers could be audited during the inspection.
- The trust's reported mortality rates for surgical procedures remained within the expected range for the hospital.
- The trust surgical site infection (SSI) rate data (July to September 2013), published by Public Health England: Surgical Site Infection Surveillance Service, showed that, from a total of 39 operations, 7.7% patients developed an SSI compared to 5.8% over the previous four periods. The percentage of patients who developed an SSI in all hospitals for the previous five years (October–December 2008 to July–September 2013) was 1.7%. This meant that people were at increased risk of SSIs, compared to other hospitals.
- The NHS asked patients about their health and quality of life before they had an operation and about their health and the effectiveness of the operation after it. This helps the NHS measure and improve the quality of its care. The Patient Reported Outcomes Measures (PROMS) between 1 April 2013 and 31 December 2013 for hip or knee replacement surgery for this trust, as analysed by the Health and Social Care Information Centre (HSCIC) indicated that the trust was a significant negative outlier. This meant that people having hip or knee replacements at the hospital did not report as much improvement in their health or quality of life as patients in other hospitals.

Competent staff

- Staff said they received an annual appraisal. The elective services dashboard dated February 2014 confirmed that 82% of staff had a completed personal development record.

Multidisciplinary working

- Members of the multidisciplinary team, such as doctors and nurses, were involved in ward rounds and attended relevant meetings.
- There were arrangements in place for working with social care partners in safeguarding investigations.
- The trust had dedicated pharmacists for elective services.

Seven-day services

- Physiotherapists said that all orthopaedic patients had access to physiotherapy services seven days a week.
- There were arrangements in place for access to radiology, other diagnostic services and pharmacy services out of hours.
- The general surgery standards review conducted by the Healthier Together team in November 2013 confirmed that suitably qualified doctors were available to assess or treat acutely unwell patients within 30 minutes. The review also found that doctors escalated concerns to a consultant when required.

Are surgery services caring?

Good

People spoke positively about the staff. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust involved people who used the service and those close to them as 'partners' in their care and treatment.

Staff supported people to make informed decisions, although more work was needed to ensure that people had all relevant information. Staff provided patients and those close to them with the support they needed to cope emotionally with their care and treatment.

Surgery

Compassionate care

- During the inspection, we observed staff treating patients with compassion, dignity and respect. Call bells were answered promptly and patients told us “the staff are very caring here” and “I am very happy with the care I am receiving”.
- Staff completed ward rounds every two hours to ensure patients were comfortable (‘intentional rounding’).
- During a ward round, doctors introduced themselves to patients and drew curtains to maintain patients’ dignity.

Patient understanding and involvement

- Patients told us they were fully involved with their care and treatment. Patient records detailed discussions between staff, patients and relatives.
- Patients said they had had no prior information telling them they may have to wait for a bed on their day of surgery .

Emotional support

- The trust had a Rapid, Assessment, Interface and Discharge (RAID) team. The team assisted clinical staff with patients’ mental health needs, including drug and alcohol problems.
- Registered mental health nurses were part of the RAID team. They also carried out assessments for anxiety and depression and were able to refer patients to counselling services.

Are surgery services responsive?

Requires improvement

The trust did not plan and deliver its services to meet the needs of different people. Patient access to surgery was limited by hospital capacity; this resulted in last-minute changes to the theatre lists. The trust did not take adequate steps to ensure that people accessed its services in a timely way. Patient flow was disorganised, resulting in poor patient experience of the service. Patients were waiting in corridors prior to surgery.

Staff took account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge and at transitions. The trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- On the elective unit, patients had been waiting in a corridor outside a ward for up to five hours. Patients said they had had to wait in the corridor from 7am until they were admitted to a ward. These patients were ‘nil by mouth’ as they were waiting for surgery scheduled that day. In several cases, the duration of ‘nil by mouth’ exceeded Royal College of Nursing guidance, especially for oral fluids, due to uncertainty about timing of their surgery.
- Patients raised concerns about the wait and the lack of information. They did not know when they would be allocated a bed.
- The trust procedure was that patients had to be admitted to a bed before their surgery could go ahead. Staff said there were no beds available until other patients were discharged.
- Managers said that admitting an elective patient into a bed was an ongoing issue at the trust. This meant that, on the day of surgery, staff changed the theatre list according to when patients were allocated a bed.

Access and flow

- The trust performed ‘similar to expected’ for their patient ‘referral to treatment’ times (e.g. the percentage of patients waiting over 18 weeks) for both the admitted pathway and non-admitted pathway.
- Prior to the inspection, we received concerns that the trust prioritised patients who had not breached the 18-week threshold over those who had. The NHS standard contract imposes a financial penalty for admitting patients who breached the 18-week threshold (up to 2.5% of elective revenue every month).
- The trust reported that, as of April 2014, 25 (19% of) paediatric trauma and orthopaedics patients had been waiting 19 or more weeks for their treatment.
- Staff were unclear who made decisions about which patients went to surgery and when.
- Two staff members showed us their lists of patients who were waiting for surgery over 18 weeks and told us that some of these patients had complained to the trust about the wait. They said that these patients now had dates for surgery, which showed that the trust was responsive to patient complaints. However, the staff members were concerned that this indirectly

disadvantaged those patients who could not complain about the wait; to illustrate their concerns, the staff identified other patients on the list who had limited capacity, were frail or otherwise vulnerable.
- The trust performed 'similar to expected' for their diagnostics waiting times (e.g. the percentage of patients waiting over six weeks).
- The trust performed 'worse than expected' for their percentage of patients waiting longer than 62 days for first treatment from their NHS cancer screening referral (between July 2013 and September 2013).
- The trust performed 'similar to expected' for their percentage of patients waiting longer than 62 days for first treatment from their urgent GP referral. The proportion of patients whose operation was cancelled was 'similar to expected' and the proportion of patients not treated within 28 days of last-minute cancellation due to a non-clinical reason was 'similar to expected.' (Department of Health's Quarterly Monitoring Cancelled Operations, March 2014).
- Information provided by the trust showed that, between 8 December 2013 and 19 May 2014, 15 operations were cancelled due to a bed not being available. This is within the national norm.
- The trust had nurses who had combined anaesthetic and recovery nurse responsibilities. This ensured continuity of care, but staff said that it impacted on patient flow through the department when both nurses allocated to a theatre were required to remain in recovery. The next operation could not be started until one nurse became free.
- The endoscopy unit was well laid out and organised. Patient flow was smooth with minimal waiting.

Meeting people's individual needs

- The information leaflets available in the department did not represent all of the main languages spoken in by the local community. However, staff had access to translation services.
- The trust had a learning disabilities coordinator and staff referred patients to the coordinator when required. Patients with a learning disability were encouraged to take their hospital passport with them. The hospital passport detailed "Things you must know about me", "My likes and dislikes" and "Things that are important to me". Staff were aware of the passport and its value.

Learning from complaints and concerns

- Staff discussed complaints investigations at ward meetings.
- The Friends and Family Test results were displayed on the wards. In February 2014, 85% of patients in the elective unit (out of 54 responses) recommended the service. 96% of the surgical unit (28 responses) recommended the service and 85% of the trauma unit (48 responses) recommended the service. One comment from the trauma unit stated: "[the hospital] has improved so much since my last visit". 60% of patients on the endoscopy unit (33 responses) recommended the service.

Are surgery services well-led?

Requires improvement

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for people. Some staff were clear about their responsibilities and identified, understood and managed risks, but whilst the trust had done work on service measurement, the service did not yet have an adequate system in place to ensure that staff regularly considered quality and performance. This resulted in a lack of robust planning for patient access and flow through the service.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The trust took steps to engage with people who used the service, public and staff, however, more work was needed to improve response to the Friends and Family test.

Vision and strategy for this service

- The trust vision was visible throughout the wards and corridors. Staff knew and could quote the vision.

Governance, risk management and quality measurement

- The trust had a quality dashboard that it used to monitor the quality of care they provided. However, staff had not identified problems with pain management. There were no systems in place to assess or monitor problems with patient access and flow.

- Staff were not aware of any policy or protocol for making decisions about which patient accessed surgery and when. This meant that clinical and business teams had not taken adequate steps to ensure they delivered a high-quality and safe service.
- The directorate held monthly governance meetings and encouraged all staff to attend, including junior members of staff. These meetings discussed complaints, incidents, audits and quality improvement projects.
- The quality and safety lead for the trust performed trust-wide audits. One audit report, dated 20 January 2014, highlighted areas of compliance and improvement, which were detailed on an action plan.
- The ward manager completed infection control audits and results were fed back via monthly ward meetings.

Leadership of service

- The trust had executive and clinical leads who were responsible for implementing and adapting the surgical safety checklist (Five Steps to Safer Surgery, December 2010) and promoting it among staff.
- Each ward had a band 7 ward manager. There was a matron who oversaw all of the wards. Staff said the matron was visible, coming to each of the wards at least once a day.
- Problems with service provision were not adequately addressed.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff repeatedly spoke of a flattened hierarchy and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- The department expected staff to be open and honest and encouraged this at all levels.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.

Public and staff engagement

- Staff said they felt engaged with the middle and senior management team and felt fully informed. The hospital newspaper dated 1 May 2014 set out the trust's values and mission statement along with a news article and information on safeguarding.
- Staff said they could and did email the senior management team with any matters. They complimented the senior management team about the timely responses they received.

Critical care

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

Information about the service

Tameside Hospital NHS Foundation Trust provided critical care services in several locations at the hospital. The combined intensive therapy and surgical high dependency unit (ITU/SHDU) cared for up to eight patients. The combined medical high dependency unit (MHDU) and coronary care unit (CCU) had a further six beds. Temporary care for people needing an ITU/SHDU or MHDU bed was sometimes provided in the theatre recovery room ("recovery") and some very ill patients were also sometimes looked after in the medical assessment and admissions unit (MAAU) or respiratory ward (Ward 45).

We spent time in the ITU/SHDU, the MHDU, CCU and recovery. We spoke with three patients and three visitors. We spoke with doctors, nurses (including the critical care outreach team), a nursing auxiliary, administrative staff, the head of quality and risk and the general manager for elective services. We observed interactions between staff and patients. We looked at information and records provided by the trust before the inspection and during the visit.

Summary of findings

Staff were caring but the trust did not plan and deliver its services to meet the needs of local people. The documentation available for staff to record patients' care was not designed for use in a critical care service. Patients did not consistently have access to timely assessments by medical intensive care specialists. The overall space available in the unit was limited and some key equipment was incomplete or unavailable. The occupancy levels were above the England average. 70% of nurses in the intensive treatment unit had completed their post-registration intensive care training although there are plans in place for the remainder to complete the training. Recruitment of a critical care educator is underway. Patients were routinely cared for in CCU by a team of nurses who did not always have the appropriate skill mix. During the patient's recovery, patients had an outstanding level of access to physiotherapists, whereas patients' access to speech and language therapists did not meet best practice standards.

Although they had plans to reorganise the service, the trust did not have a credible strategy to deliver high-quality care and promote good outcomes for people in critical care. The trust could improve the systems for monitoring incidents and safety. Senior managers were not aware of the issues relating to capacity and staffing in the critical care service. These concerns did not feature in the trust's risk registers and had not been adequately considered in the strategic

Critical care

plans for the critical care service. The trust had not collected the relevant performance data to assist the trust in monitoring the service nor adequately engaged with staff.

Patients and their families said staff were attentive and caring. Staff worked well as a team, felt supported by their line managers, and were highly motivated to provide patients with the best care possible. They treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. People and those close to them spoke positively about their experience in critical care. However, we were unable to measure the satisfaction (outcomes) for people using the service, as the trust did not have an adequate system in place to monitor them.

Are critical care services safe?

Inadequate

Although the service's track record on safety showed low levels of harm from care, the trust did not adequate support staff to react to changes in risk levels in the service. The service did not assess and monitor safety in real-time, such as by maintaining medication stock or safe staffing levels (although there was an escalation strategy for staffing). The documentation available for staff to record patients' care was not designed for use in a critical care service. The overall space available in the unit was limited and some key equipment was incomplete or unavailable. There was no rolling programme for the updating or replacement of equipment.

There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. However, the trust did not ensure staff learned when things went wrong.

Incidents

- There had been no Never Events reported relating to critical care services at the trust, in the last year. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The trust had recently introduced a new incident reporting system. This required staff to report all incidents electronically through the trust's intranet. Staff knew about this new system, although some had not yet used it.
- A nurse described a recent reportable incident. Information in the schedule of incidents provided by the trust stated that the possible reason for the event was "patient's deteriorating condition and nursing (agency) staff extremely busy". The nurse was aware of some actions taken regarding this incident but was not aware of any written guidance or feedback resulting from the investigation of the incident.
- We saw an incident form relating to a suicide attempt by a patient in 2012. Staff did not know what action, if any, the trust had taken to reduce the risk of a similar incident happening in the future. The incident was not

listed on the schedule of incidents provided by the trust. The Director of Quality and Governance was not aware of the event which had happened before they were in post.

- Some issues on the ITU/SHDU were not reported as incidents. As a result these were not identified on the trust's risk register. The incidents included the lack of a cardiac output monitor, non-clinical transfers, out-of-stock medication, and level 3 patients (those needing intensive care) being cared for outside of the ITU/SHDU (i.e. in theatre recovery).
- Staff said that beds in ITU/SHDU were sometimes taken out of use due to not having sufficient staff with the necessary skills mix. They confirmed that they had never been instructed to take a patient when it would have been unsafe to do so. This is good practice however the beds were not formally closed and staff did not report these.
- A consultant wrote a note in the records of one patient in the MHDU/CCU, stating that they intended to report an episode of poor clinical care as an incident. However, at the time of the inspection, this had not yet been reported.

Safety thermometer

- Safety Thermometer information was displayed in both ITU/SHDU and MHDU.
- The critical care service had low levels of infections and pressure ulcers.

Cleanliness, infection control and hygiene

- Intensive Care National Audit & Research Centre (ICNARC) data for January to June 2013 showed low levels of infection in ITU/SHDU. The trust was not able to provide more recent ICNARC data.
- Some clinical areas, corridors and waiting areas were clean and tidy. Contracted staff cleaned non-clinical areas. However, there were no records of the cleaning by the contracted cleaning staff.
- Staff said that the room used for cardiology surgical procedures (the 'pacing room') was cleaned after every procedure, in addition to the routine cleaning by domestics every day. However, the equipment trolley in the pacing room, which was already prepared for a procedure, was dusty and was touching the patient trolley. The pacing room was also used as a storage facility for equipment. Cleaning liquids were stored on the floor under the sink. This meant that staff did not adequately minimise the risk of cross-contamination.
- When we returned for an unannounced site visit on 17 May, we found that the pacing room was still dusty and filled with equipment. Staff confirmed that procedures had taken place in this room between our two site visits
- An auxiliary nurse or registered nurse cleaned equipment used for patient care. Cleaning records kept by the auxiliary nurse were only filled in occasionally. Staff said this was because there was only one part-time person employed in this role. This meant that auxiliary nursing staff could not monitor which cleaning tasks had been done nor plan their work accordingly.
- Procedure trolleys were stocked and ready for patient use. It was not clear whether some items were clean, as records were inconsistent and some items did not have "clean stickers". Staff assumed they were clean.
- The trust had recently installed disposable curtains around the beds in ITU/SHDU. These were labelled so that staff could record the dates they were last changed. The trust's infection control lead nurse said these were changed when a person moved out of a bed, or sooner if they became soiled.
- Some staff in ITU/SHDU were less clear about when the curtains should be changed. There was no system for checking the dates on the curtains to make sure they had been changed. This meant that staff could not assure themselves that the curtains were changed when required.
- Staff used personal protective equipment such as disposable gloves, aprons and face visors appropriately. Hand gel was available at entrances to the units and at each person's bed. Staff used the gel and washed their hands as expected. This reduced the risk of cross-infection.
- There were no visual bedside prompts to inform staff when a patient being nursed in the open unit had an infection. This meant that visiting healthcare professionals, including agency staff, may not be aware of the patient's isolation status and the need to take appropriate measures against the risks of cross-infection.
- The visitors' toilet had a closed toilet roll dispenser to help reduce the risk of cross infection. However, one of the grab rails had two ordinary toilet rolls resting on it. This could present a risk of cross-infection.
- The ITU/SHDU had one single room (with no gowning lobby or en-suite facility) available for patients who required isolation due to the presence of infection. This was to minimise the transmission of the infection to

others or for patients who were immune-compromised and needed protecting from the transmission of infection from other patients. The MHDU had no isolation facilities.
- Staff said that if more than one person requiring critical care needed to be isolated they might need to be transferred to another hospital with suitable facilities. Moving a critically ill patient because of cross-infection risk may not be in their best interests and could place them at risk of harm.

Environment and equipment

- Fire evacuation information was displayed and available for visitors to read.
- The allocation of the six MHDU/CCU beds varied between the two specialities. The trust also admitted high dependency surgical patients to these beds on occasion. These beds sat outside of elective services division and were not directly managed by the critical care matron.
- Recovery was well equipped for the occasions when it was used to provide temporary ITU space.
- The ITU/MHDU environment provided limited space between each bed. Staff acknowledged the available space was inadequate for providing safe care and treatment.
- Staff used the tenth bed space as a storage area because there was insufficient room in this bed space to care for the patient with all the necessary equipment around the bed.
- There were no bathroom facilities for level 2 (high dependency care needs) patients receiving care in ITU/SHDU. This meant that patients had to use the bathroom facilities in the next ward.
- A technician was responsible for checking the resuscitation trolley and other equipment. They also did the temperature checks for the medicines refrigerators. Records for April 2014 confirmed that they had done the necessary checks and a random check of previous months demonstrated robust compliance with the checking processes.
- Some equipment in ITU/SHDU was over 10 years old.
- There was a new 'difficult airway' trolley on the unit (in line with the Royal College of Anaesthetists recommendations) but this was incomplete and not in use. There was no signage to indicate the trolley was not in use, even though it was stored next to the defibrillator in the unit.
- Staff said they sometimes had to go to theatres to borrow a trolley or equipment. This took staff away from the unit and contributed to delays in accessing equipment during difficult and failed airway intubations.
- The ITU/SHDU was unable to carry out cardiac output studies because the unit did not have a functioning monitor for this. They could only do cardiac output monitoring if they were able to borrow equipment when the theatre team was not using it. The unit's own monitor was not working and the service contract was out of date. We note from the trust that they believe this equipment was available and working (the trust showed evidence of equipment and maintenance records); however staff told us that they did not have the equipment.
- The pacing room environment was not suitable for medical procedures. Staff had minimal room to move, as the room was small and filled with equipment. The decoration in the room prevented the pacing room from being cleaned to surgical standards. There was limited signage regarding the risk of exposure to x-rays and no light to indicate when x-rays were in use. This meant that the pacing room was not fit for purpose.
- For one coronary care patient on the MHDU/CCU who needed daily weight checks, a nurse explained that the patient could not easily stand and therefore could not move to the chair to be weighed. This meant that staff lacked important information to monitor the patient's condition, as they did not access the appropriate equipment.
- In the MHDU/CCU, the defibrillator checklist did not include the checking instructions.

Medicines

- Medicines were stored in locked cupboards within a room accessible by key card. Staff said that the nurses and a doctor on each shift had cards to unlock this room.
- There were instructions displayed in the room regarding the importance of following correct procedures and not being distracted while dealing with medicines.
- Staff stored controlled drugs safely and maintained accurate records. A nurse checked a sample of controlled drugs at our request. They asked another nurse to assist them and took care to check the labels and expiry dates as well as the quantity in stock. These matched the balances shown in the records.

- The controlled drugs records showed that night staff checked the balance of every controlled drug. Entries in the controlled drugs book were signed by two staff. A nurse explained that if they identified incomplete records, this would be reported as an incident and investigated.
- The hospital pharmacist team did periodic checks of medicines in the ITU/SHDU. The audit form they used was not version controlled. The form did not include sufficient space for information such as the date and name of the person doing the audit. There was no space to record that expiry dates had been checked or to confirm that stock levels of each item were adequate to meet the service's needs.
- The medicines room was clean and tidy but was filled to capacity. A nurse said that additional space would benefit the service.
- Staff said that medication stock on the units sometimes ran out, even though the trust pharmacy provided a 'top up' service. Nurses often had to go to the emergency store on the floor below to collect routine stock medication needed by patients. This meant that ITU/SHDU would be left without safe numbers of nursing staff for a period of time.
- Staff also reported that there were delays in obtaining drugs for patients, such as intravenous infusion of a sedative drug, as the unit's stock had run out.
- In the MHDU/CCU, staff stored sedative medications on an unlocked trolley in boxes. There was no record of which patient received which medications. This meant that medications were not stored safely.
- Between 1 April and 9 May 2014, staff reported only seven incidents relating to medication in respect of the MHDU/CCU, MAAU and intensive therapy unit (ITU). This suggested that there may be under-reporting of medication errors in these areas.

Records

- Patients' records in both the MHDU and ITU/SHDU included records of observations and risk assessments (such as Waterlow assessments relating to pressure area care). There were folders at patients' beds containing basic care information such as moving and handling assessments, pressure area care, pain scores, bowel observations and eye care.
- There was no clear information to describe the holistic care nurses should be providing and against which they could evaluate the care provided.
- Generic hospital ward protocols of care had been introduced recently, which staff said were not fit for purpose. These had replaced specific critical care documentation. Nurses said they had limited documentation for recording specific critical care planned interventions, often making handwritten amendments on the generic ward documentation.
- Nurses commenced care plans on a patient's first day in ITU, including information that the patient was sedated and ventilated. These care plans were not regularly reviewed or updated.
- Nurses obtained certain test results from the trust's IT system and transcribed these onto paper records. Nurses said this was because medical staff wanted to be able to see trends in a patient's condition. This carried the risk of information being incorrectly transcribed. Nurses said that they wanted improved and more streamlined documentation to help them care for patients.
- Many of the forms and other documentation the critical care team used were photocopies, not version-controlled printed documents. This meant that there were no controls to make sure staff were using the most recent version approved by the trust. In addition, the photocopying quality was poor so that in some cases text was distorted or missing at the side of the page.
- Staff did not consistently complete the procedure book used by the MHDU/CCU for all procedures. In some cases, the record was missing information such as the radiographer's name. This meant that the trust would not be able to adequately audit the procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a new policy about decisions relating to cardiopulmonary resuscitation. This was written with reference to the Mental Capacity Act 2005 and related national guidelines from the British Medical Association, Royal College of Nursing and Resuscitation Council.
- There was a folder in ITU/MHDU with a copy of the Act and information about its associated deprivation of liberty safeguards, a quick reference guide for assessing patients' capacity and a 'best interest decision' checklist. There were independent mental capacity assessor referral forms and deprivation of liberty authorisation request forms. This meant that doctors

and nurses had the documents they needed when decisions needed to be made about a person's care and treatment when patients were too unwell to provide informed consent themselves.
- Most of the staff knew the relevance and importance of the Act when very ill patients were unable to speak for themselves. One nurse did not understand the Act or the deprivation of liberty safeguards or how these applied to the provision of care within ITU.
- Staff did not record best interest decisions; this did not reflect best practice detailed in the Act.

Safeguarding

- Signs were displayed in the ITU/MHDU waiting area informing people that they were not allowed to take photographs or film or video within the unit. This protected patients from the risk of this being done without their knowledge or consent.
- Information about the trust's safeguarding arrangements, including contact and referral details, was displayed in several places within the critical care service.
- The ITU/SHDU administrator was unable to provide the number of staff who had attended the safeguarding vulnerable adults training as this information was not held in the local records. However, 40 out of 50 staff were in date for safeguarding children training and the remainder of the staff had training booked.
- Staff understood their responsibilities for reporting safeguarding concerns. One nurse said that they were "confident" that all concerns would be noticed and reported.
- Staff said they would contact the safeguarding team at the hospital as the first contact. They gave examples of safeguarding referrals made by the critical care team. These showed that the staff involved had recognised safeguarding concerns and responded accordingly by involving the safeguarding team.

Mandatory training

- All staff new to the trust had to complete a corporate induction week. This included input about patient focus, manual handling, initial life support training, conflict resolution and a medical equipment workshop.
- Staff working in the ITU/SHDU organised their training through an administrator based in the unit. The administrator had a system for liaising between the education centre, staff working in the unit and the e-rostering team. This helped to make sure that staff training dates could be taken into account when staff rotas were being prepared.
- Staff commented that many of the training dates were provided at short notice. This made it difficult for staff to attend because rotas were already in place and the nursing establishment did not provide for a supernumerary nurse on a shift.
- The administrator recorded and tracked staff attendance at mandatory training to help make sure staff attended at the required frequencies. However, they were not aware of all the required elements of mandatory training and were unable to provide definitive numbers for all required elements. The records they kept included basic and advanced life support training, moving and handling, conflict resolution, fire safety, child safeguarding and critical care skills.
- The records of staff attendance at fire training showed that only 26 staff out of 50 staff were up to date in this topic. This was because of an inability to access training dates.
- Training records showed that some staff had not received some role-related clinical updates such as wound care and catheter care.
- The education centre had recently published dates for Mental Capacity Act and safeguarding training. The administrator was in the process of booking places for the team.

Assessing and responding to patient risk

- Patients' care needs were categorised as levels 0, 1, 2 or 3 according to how ill they were and the extent of the care they needed. Patients whose care needs could be met on an ordinary ward were level 0, patients who were at risk of deteriorating or who were recovering but supported on the ward by specialist nurse input were level 1. Level 2 patients were those who had high dependency care needs and level 3 patients needed intensive care.
- The trust's Critical Care Outreach Services, Operational and Procedural Policy dated April 2014 was based on national guidance produced by the National Institute for Health and Care Excellence (NICE) and the Department of Health. The policy was produced to improve how staff identified and responded to patients whose condition deteriorated.

Critical care

- The policy included procedures and forms that staff were expected to use including the patient at risk score (PARS) tool and associated standards.
- There was an internal early warning scoring system used to help staff identify when a patient's health was deteriorating. A working example of this showed staff had used it correctly to identify that the patient needed a higher level of care.
- Senior management and staff explained that the trust planned to implement the national early warning score (NEWS) system for deteriorating patients.
- An audit report on inpatient cardiac arrests figures for 2013 showed a reduction in cardiac arrests from 2012. More emergency calls had been made in 2013 for deteriorating patients than for cardiac arrests. This suggested that staff were becoming better at identifying deterioration because they called for help before patients arrested.
- During our unannounced visit on 17 May 2014, we saw that one patient was admitted to the CCU on 16 May, following admission to hospital due to deterioration of their chronic heart conditions. While in the MAAU, the patient experienced acute deterioration and was subsequently transferred to the CCU. Despite regular medical reviews by doctors at all grades throughout the patient's stay in hospital, there was limited investigation into why the patient suddenly deteriorated. The care plan specified by doctors, such as daily weights, was appropriate to manage the patient's long-term conditions but did not adequately specify how staff should monitor the patient's acute condition, such as through regular blood tests and fluid balance charts.

Nursing staffing

- The unit's nursing establishment was calculated on the unit caring for six level 3 (intensive care) patients and two level 2 (high dependency care needs) patients. If there were more than six level 3 patients, additional staff would be required or a level 2 bed would need to be closed. Staff confirmed that ratios of one nurse to two level 2 patients and one nurse to one level 3 patients were maintained.
- There was rarely a supernumerary nurse on duty as set out in the Intensive Care Society standards because the team leaders on duty were also responsible for the direct care of a patient during their shift.
- Staffing levels were displayed in the ITU/SHDU and MHDU to make people aware of the numbers of staff on duty. The overall staffing establishment in ITU/SHDU was four band 7 nurses, seven band 6 nurses, 34 band 5 nurses and one part-time nursing auxiliary.
- The staffing levels on MHDU/CCU were adequate for six level 2 patients but staff said there were currently five whole time equivalent (WTE) vacancies which would be increasing to seven by June 2014.
- E-rostering statistics provided by the trust indicated low levels of sickness absence in ITU/SHDU.
- Staff said that the outreach team provided the day-time nursing care when patients had to be nursed in the recovery room due to lack of available beds in ITU. This meant that the outreach team was not always immediately available to answer calls for help elsewhere in the hospital.
- The nursing auxiliary was employed for 30 hours a week. Staff had told managers this was inadequate because they provided important aspects of patient care such as washing, helping with meals and cleaning bedside equipment. Agency nursing auxiliaries were sometimes used but this did not ensure continuity of care.
- A ward clerk supported the clinical team in ITU/SHDU four days a week. Staff said this was insufficient for the volume of work (including the recording of ICNARC data) to be done and they felt that a minimum of five days a week, but preferably seven, was needed.
- Agency staff use was below 20% and so within levels recommended by the Intensive Care Society. It was a policy at the trust to use overtime as a last resort. Part-time staff were used as the preferred option because they were familiar with the unit and with patients' needs.
- The critical care service did not have a clinical nurse educator in post. This was because the position was currently vacant.
- There was a handover between ITU/SHDU nurses at the start of the day and night shifts. This took place away from the clinical area and was attended by the nurses coming on duty and the team leader from the nursing team going off duty. The nursing team handover was followed by more detailed bedside discussions between the individual nurses assigned to each patient.
- Staff said that nursing team leaders were rarely able to take part in the medical staff ward round because they needed to stay with the patient they were responsible for. Staff also confirmed that the critical care service

matron did not take part in the medical ward round either. This meant that the senior nursing team were not able to gain an overview of ward round discussions to help them plan the nursing team's priorities.

Medical staffing

- There was a designated lead consultant for intensive care as set out in the Intensive Care Society standards.
- Only five of the 15 consultants covering on call had regular daytime commitment to intensive care. Referrals from ward-based teams for review by the critical care team went initially to the anaesthetist covering theatres and were only reviewed by the critical care team after this initial review.
- During the night and at weekends the ITU/SHDU was covered by a middle grade or specialist trainee with sole responsibility for the ITU/SHDU. They were supported by a consultant who was also responsible for theatre and obstetric activity. MHDU/CCU had no formal critical care medical cover either in or out of hours.
- There were multiple medical handovers. In the mornings the night ITU registrar handed over to the day registrar. The consultant was not present for this but took part in a separate handover later in the day. This process did not appear to be formalised which created the potential for miscommunication.
- The trust used a minimum amount of locum cover. This was because the sufficient doctors were available from the middle tier of medical staff including non-consultant career grades and trainees.
- Trainee doctors were taking part in an anaesthetics training programme in line with Faculty of Intensive Care Medicine (FICM) standards. ITU/SHDU was accredited with FICM to provide intermediate training for doctors.
- On weekdays there was one consultant to a maximum of eight level 3 patients. This was within the Intensive Care Society standards. At weekends there was no routine review by an intensivist consultant, although staff said the on-call anaesthetic consultant may provide a review.
- During our unannounced visit on 17 May 2014, staff said that the trust had initiated a daily ward round by the anaesthetic team in the MHDU. This was in response to concerns we raised about medical staffing in the MHDU during our earlier, announced site visits.

Major incident awareness and training

- There was a trust-wide major incident policy setting out the framework for how the trust would manage additional patients and liaise with emergency services, families and the media.
- There was a copy of the plan accessible to staff on the ITU/SHDU. Staff knew of its existence, but struggled to find it.

Are critical care services effective?

Requires improvement

Patients did not consistently have access to assessments by intensive care specialists. Staff did not adequately assess delirium. Some protocols and guidance had not been updated in several years.

People and those close to them spoke positively about their experience in critical care. However, we were unable to measure the patient satisfaction (outcomes) for people using the service, as the trust did not have an adequate system in place to monitor them.

The staff were committed to their work and were highly motivated to provide patients with the best care possible. Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance.

The trust did not ensure that staff enabled the effective delivery of care and treatment. Only 70% nurses in the ITU/SHDU had completed their post-registration intensive care training. Patients were routinely cared for in other areas of the hospital, by a team of nurses who did not have the appropriate skill mix. The trust supported and enabled multi-disciplinary working within and between services across the organisation, as well as with external organisations. The trust had systems for ensuring that staff had all done the training needed for their role and were monitoring this with the intention of increasing the numbers of staff who were up to date with relevant training.

During the patient's recovery, patients' access to physiotherapists was excellent, whereas patients' access to speech and language therapists did not meet best practice standards.

Critical care

Evidence-based care and treatment

- The trust's policies and procedures relevant to the critical care service used national evidence-based guidelines as source material for the content. These included guidance from the Department of Health, the Intensive Care Society, NICE and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) as well as the relevant medical bodies such as the Royal Colleges and British Medical Association.
- The Intensive Care Society standards say that an intensive care consultant must review all patients admitted to critical care in person and their treatment plans. Because only five of the 15 consultants providing out-of-hours cover were intensive care specialists, this was only possible for people admitted on weekday and for out-of-hours periods when one of the five was available.
- Staff did not adequately assess delirium (acute confusion). Delirium is common in patients needing to receive critical care services and a sign that they are very ill. This can present itself in a variety of ways and can be distressing for the person and their family. It is important that the signs of delirium in a patient are recognised and taken account of in their treatment.
- The outreach team were participating in an NCEPOD audit relating to sepsis. This showed a commitment to contributing to learning within the heath sector.
- The trust used care bundles to assist in the management of patient care. These were audited and missing information was highlighted in the audit records.
- The trust had written policies for the transfer of patients within the hospital (known as intra-hospital transfers) and between hospitals (known as inter-hospital transfers). There was also a detailed guidance document for staff outlining the exact procedures to be followed when moving critical care patients from one location to another. Both documents took into account various national guidance from bodies such as the National Patient Safety Agency and the Intensive Care Society.
- The cardiology patient pathways lacked consistency. Patients undergoing pacing procedures were not always allocated a bed in the CCU, because the beds were used for medical or surgical high dependency unit patients.
- Staff involved in pacing procedures were not able to provide a standard operating procedure for pacing.

Pain relief

- The ITU/SHDU had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant. This was contained within the bedside folder.
- Some protocols within this folder had not been updated for several years: for example, glycaemic control 2009 and draft sedation scoring 2006.

Nutrition and hydration

- There was a designated lead dietician for the critical care service. A dietician provided routine input from Monday to Friday and took part in ward rounds. There were protocols for initiating appropriate nutritional support out of hours.
- The nursing auxiliary assisted people who were able to eat their meals orally.
- Patients being weaned from ventilation did not routinely have a speech and language therapy assessment to determine their ability to swallow. This did not meet Intensive Care Society standards and could have an impact on patients' recovery.

Patient outcomes

- CQC's intelligent monitoring system (which looks at a wide range of data, including patient and staff surveys and hospital performance information) did not identify any outliers relating to critical care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care people receive.
- Patients and relatives were positive about the care they had received and we met people who had recovered sufficiently to be able to leave ITU. Letters and cards from past patients and families provided further evidence of people's recovery.
- The trust did not have NHS Friends and Family Test results specific to critical care.
- Before the inspection, the trust sent us details of their ICNARC results for the period from October 2011 to March 2012.

- Due to problems with more recent data, the trust was only able to provide us with part of the ICNARC data for 2012/13 and also for 2 January 2013 to 27 June 2013. The trust was unable to provide the most recent and full data for a national clinical audit

Competent staff

- Team leaders said that they did their best to make sure that there were staff with a suitable skills mix on duty on every shift.
- There was a structured induction programme for new staff. A manager explained that all staff did an internal course on critical care when they joined the team.
- There was also an induction folder for agency staff containing essential information. All agency staff were expected to read this and sign to confirm they had done so before they started work.
- The trust had arrangements to provide staff with supervision and appraisal. Staff confirmed that they received appraisals each year. Some staff were unclear about the frequency of structured supervision but said that senior staff were approachable and that they could ask for informal support whenever they needed to. The lack of regular structured supervision meant that learning, development and performance needs may not be identified or acted on.
- 70% of nurses on ITU/SHDU had completed the expected post-registration academic critical care training programme while approximately 73% of the nurses on MHDU had done so. The expected level was 75%. A manager explained that further staff were in the process of doing this training.
- Beds in the combined MHDU and coronary care unit were often used to provide care to surgical high dependency patients. Staff used to providing mainly coronary or medical care may not have the relevant skill set or level of experience to care for people who have significant care needs after surgery.
- Critically ill patients had been accommodated in recovery when ITU/SHDU was full. While the team in recovery were supported by the critical care outreach team and by phone support from ITU/SHDU staff, they may not have the appropriate skills mix to meet the needs of intensive care patients.
- Clinical staff on the MAAU and MHDU/CCU did not demonstrate adequate understanding of treating deteriorating cardiology patients. This meant that staff had not identified patients as needing specialist urgent care and patients did not promptly access the investigations and treatment they needed.

Multidisciplinary working

- There was a range of professionals available to support the care and treatment of people receiving critical care services. Physiotherapy input was available every day and a dietician was available Monday to Friday. A member of the microbiology team took part in ward rounds five days a week as did members of the pharmacy team. Speech and language therapists were available by referral when needed.
- People who were well enough to move from ITU/SHDU had a discharge pack which supported the process of preparing them to receive a less intense level of care. At this stage people were also introduced to the critical care outreach team who provided follow-up support to patients when they left ITU/SHDU. Staff recognised this process as crucial due to the level or familiarity and trust developed between people in ITU/SHDU and the staff team.
- There was adequate outreach cover within the trust. Communication between ward staff and the outreach team was good.
- Part of the role of the outreach team was to work with ward staff when patients were deteriorating and needed a greater level of care. One family described how one of the critical care outreach team had been to see their relative on a ward and identified that they needed to be in a critical care bed.
- The team of staff that accompanied patients to theatre or to have scans included: an ITU/SHDU technician, porters, an ITU nurse and a doctor. This meant that staff were readily available to deal with any clinical or technical issues while en route.
- A specialist organ donation nurse used an office within the critical care service. Their explanations reflected good practice in respect to liaising with staff and families regarding organ donation.
- The physiotherapy team were responsible for ensuring that patients' rehabilitation needs were assessed within 24 hours of admission and providing ongoing physiotherapy to contribute to their individual goals.

Critical care

Seven-day services

- A consultant in intensive care medicine was not available 24 hours a day, seven days a week, to attend a patient within 30 minutes as set out in Intensive Care Society standards.
- Consultant cover out of hours was often provided by a surgical senior who may not always be a critical care specialist. Anaesthetists also provided out-of-hours cover.
- Imaging services and physiotherapy were available seven days a week. There was no dietician or pharmacy support at weekends. However, there were clear guidelines on initiating nutritional support out of hours.

Are critical care services caring?

Good

Staff recognised that being a patient in critical care could be distressing for people and their families. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. The trust involved people who used the service and those close to them as 'partners' in their care and treatment. Patients and their families were positive about the staff team. They said they were attentive and caring.

Staff supported people to make informed decisions. There was a wide range of information available for visitors. Staff provided patients and those close to them the support they needed to cope emotionally with their care and treatment.

Compassionate care

- Staff treated people in a warm and caring way.
- Patients spoke positively about the staff; one person commented "They make you feel at ease and that makes you feel better".
- Staff showed respect and consideration for patients and recognised that small things made a big difference to how a patient felt, such as washing a patient's hair.
- Medical staff spoke with patients and, where possible, involved them in elements of their care and decision-making processes. Due to the nature of the care provided on the ITU/SHDU unit, patients could not always be directly involved in their care.
- Whenever nurses or doctors attended to patients, they drew the curtains around the beds to give greater privacy. A patient said that the staff always did this and that if they asked the staff to close the curtains they did.
- The service had a 'Dignity in care' noticeboard in the ITU/SHDU corridor. This provided the name of the service's dignity champion as well as information about dignity in care published by the Royal College of Nursing.
- There were numerous recent 'thank you' cards on a noticeboard near to the waiting room in ICU/MHDU. Some people had written at length about why they appreciated the care they or their relative had received. People described the compassionate and attentive care they had received and were full of praise for the "hard-working" staff team.

Patient understanding and involvement

- Staff were aware that the level of specialist equipment needed to look after patients in ITU beds in particular could be distressing for their families and friends. To help support people visiting the unit for the first time, staff had created a display showing photographs of the main items of equipment used together with brief explanations of what these were used for. There was also information available about visiting arrangements and the unit's philosophy.
- Staff aimed to provide continuity of care by as far as possible, allocating named nurses who were familiar with patients and their care.
- Visitors and patients said that staff generally kept them well informed about their condition and treatment. One person said "They all explain everything" and added that when they had been very ill, "They explained everything to my family very well".
- There was a suggestions box in the corridor leading to ITU/MHDU. The box was empty and the nurses did not know if there were any written results available from past comments. However, one nurse said that the visitors' toilet had been installed as a result of comments from visitors.
- There was a wide range of information available for visitors in the form of leaflets and posters. This included details of local carer support groups, visiting and parking charge information and a range of leaflets about the symptoms, care and treatment of people needing critical care services.

Critical care

Emotional support

- There was no specific follow-up clinic for patients of the critical care service when they left hospital. However, there was an informal process whereby the team in ITU/SHDU encouraged long-term patients to come back to the unit to talk through any concerns or issues they had.
- There was a bereavement service available and a letter was sent to bereaved relatives after the death of any patient.
- Information about local mental health services, including support organisations, was available in the waiting room.

Are critical care services responsive?

Inadequate

The trust did not plan and deliver its services to meet the needs of local people. The occupancy levels were above the England average. The capacity issues meant that patients were not always cared for in the most appropriate setting for their needs. The trust did not take adequate steps to ensure that people accessed its services in a timely way. This impacted on other services at the hospital including surgery and coronary care.

Staff on CCU frequently cared for patients who required critical care, when no critical care bed was available.

Staff took account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge and at transitions. Staff routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Information published by the Department of Health regarding bed occupancy levels showed that between November 2013 and January 2014 the trust's critical care occupancy was 87.9% compared to the England average of 82.9%.
- On the evening of the 6 May 2014, the ITU/SHDU was full with eight patients; there were six patients on the MHDU/CCU and two patients in theatre recovery ("recovery"), one of whom was ventilated. The critical care service was very busy and the level of out-of-hours cover, without a critical care specialist on site for extended periods, appeared inadequate for the volume of activity.
- There was a specific policy for the care of people needing intensive care to receive this in recovery if a bed was not available in ITU. The document recognised that this was a 'largely unsatisfactory' solution and set out detailed procedures to minimise the risk to patient safety. The existence of this policy supported the view that the short-term use of recovery to add to capacity had been normalised.
- Staff said they routinely looked after ventilated patients in recovery and that patients receiving intensive care there caused great difficulty in managing relatives and maintaining the privacy and dignity of other recovery patients.
- The trust could not provide up-to-date ICNARC data for transfers of patients out of the ITU for non-clinical reasons.
- Information from the trust showed that, in February 2014, two patients had been sent to another hospital due to lack of ITU beds.
- Most staff described a "mismatch" between the hospital's capacity and the demand for critical care beds at the trust. Staff said that this had a negative impact on patients, such as those in renal failure, when a critical care bed was not available.
- A random sample of 25 incident forms from 2013/14 showed that three related to demand exceeding capacity and a ventilated patient being in an MHDU bed rather than in ITU/SHDU.

Access and flow

- The trust could not provide the percentage of patients admitted to ITU/SHDU within four hours of referral because they did not have up-to-date ICNARC information at the time of the inspection.
- Observations, records and conversations with staff demonstrated that some patients were not admitted within four hours of referral. Staff cared for a significant number of patients in recovery or in the MHDU/CCU.
- There was no operational or admissions policy for the six beds in the combined MHDU/CCU, which the trust used for MHDU, CCU, and SHDU patients. There was no

clear information about who made decisions about which patients should be admitted to the MHDU or about where responsibility lay for the risk management regarding competing priorities and demands for beds.
- Due to demand for critical care beds, some people were moved from ITU/SHDU sooner than expected and without the usual planning and preparation process.
- Staff worked hard to enable people to move out of critical care beds once they were medically fit to do so and worked closely with the bed managers.
- People were sometimes moved from an ITU bed during the night. Several people mentioned the distress and anxiety that this caused to the patients and relatives.
- Intensive Care Society standards state that discharges from critical care should take place within four hours of the decision to discharge. This standard was not being met because the in-house target for discharge was 24 hours.
- Staff said they used the single-sex care standard to help expedite transfers once a patient no longer needed to be looked after by the critical care team. Staff said this had helped to improve patient flow and the number of delayed discharges from critical care beds.
- The trust could not provide data to show the loss of bed days due to delayed discharges.

Meeting people's individual needs

- Some visitors said that the waiting room sometimes became very full in the evenings and they did not feel that it was large enough.
- The waiting area in ITU/SHDU included a disabled access toilet with enough space for a wheelchair user. The toilet had well positioned grab rails and a low level basin and mirror. There was a safety lock, a call bell with a floor length cord and low level hooks for bags or coats. This ensured that visitors with mobility problems had access to a suitable toilet.
- The facilities in the relatives' room included a prayer mat.
- There were set visiting times in the afternoon and evenings. Staff said that they tried to be as flexible as possible depending on the family's specific circumstances or the patient's condition.
- Most of the information available for visitors was in English, although some leaflets were provided in other languages. A poster informed people that an interpretation service was available for them to use.
- Suitable equipment for caring for morbidly obese patients was available and the safe management of such a patient was witnessed during the visit.
- A room with two sofas was available for private discussions with relatives. There was a kettle for people to make a hot drink. The room was also used as a place for relatives to stay overnight, even though it had no beds. This meant that if people were using the room overnight the room was not available for other people.
- On 7 May 2014 the six beds in MHDU were occupied by four people needing high dependency care for medical reasons and two for surgical reasons. This meant that there were no coronary care beds available should they have been needed.

Learning from complaints and concerns

- Information for people about how to make a complaint, raise concerns or compliment the service was displayed where visitors would see it. The information included details of the Patient Advice and Liaison Service.
- Several staff described the value of dealing with people's concerns straight away before they developed into more significant complaints. Staff said that when a concern was raised with a member of staff this would be referred to the most senior nurse on duty who would then inform the matron for the service.
- Some visitors said they had mentioned a concern and that staff had listened to them and put things right.

Are critical care services well-led?

Inadequate

Although they had plans to reorganise the service, the trust did not have a credible strategy to deliver high-quality care and promote good outcomes for people in critical care. The governance arrangements did not ensure that staff were clear about their responsibilities, or that staff regularly considered quality and performance, and staff identified, understood and managed risks. Senior managers were not aware of the issues relating to capacity and staffing in the critical care service. These concerns did not feature in the trust's risk registers and had not been adequately considered in the strategic plans for the critical care

service. The trust had not collected the relevant performance data to assist the trust to identify key pressure points. The trust was not using other information, such as ICNARC data, to help them monitor the service.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. Staff worked well as a team and felt supported by their line managers. The trust did not adequately engage with staff or act appropriately on staff feedback.

Vision and strategy for this service

- The trust had recently integrated the critical care service into the elective services division. This had only been since the beginning of April 2014 as part of changes to the governance structure at the trust.
- The elective services division now included theatre, surgery and critical care with key clinical input from the anaesthetics team. This was part of a re-organisation programme which the trust hoped would improve lines of accountability.
- MHDU remained within the medical division temporarily. This created challenges due to it having separate management from ITU/SHDU and the outreach service.
- The trust had plans to move the MHDU beds to the same floor as ITU/SHDU, to create a more cohesive and self-contained critical care department with increased storage capacity. The trust had prepared a business case for the move.
- The plans would not result in an overall increase in designated critical care beds. This meant that despite of the potential benefits of all the beds being in one location, the problems relating to capacity and flow within the critical care service were likely to continue.
- The Trust has a plan in place to ensure that a supernumerary nurse is on shift to provide leadership and support; despite the co-location of the six MHDU beds with the 10 physical bed spaces of ITU/SHDU.
- The general manager had not been aware of the extent to which capacity was an area of concern within critical care. This did not appear to have been taken into account in developing the planned changes.
- The general manager said that the changes were “an internal matter” and there had been no consultation with the local critical care network or commissioners regarding the proposed changes. This meant that the broader picture regarding critical care capacity within the network area had not been considered.

Governance, risk management and quality measurement

- Staff did not know what the main themes of incidents and risks within the critical care service were.
- Staff failure to report some incidents meant that the organisation was unable to respond to ensure the matters were addressed promptly and the necessary learning took place.
- There was no evidence in the risk registers that the concerns regarding bed capacity and the consequences for critically ill patients were reported as incidents. This meant that these risks had not been identified by the trust as a priority area for action.
- The April 2014 Patient Safety Incident Report combined statistics about critical care services with the emergency services data. This meant that we were unable to look at the figures specifically for ITU/SHDU and MHDU.
- Staff had access to a folder containing copies of the trust’s Risk Management Process Guidance and the Risk Management Strategy, Policy and Guidance. These were recent, version-controlled documents. The folder also included a risk register flow chart and risk assessment record template for staff use. This meant that staff had access to up-to-date information about how the trust intended to manage risk.
- The same folder contained a large number of handwritten risk assessments which were filed alphabetically. There was a handwritten index at the front of the file listing the contents. The risk assessments spanned at least three years from 2011 to more recent additions in 2014. There was no system in place to check that the assessments were still valid and relevant.
- Staff could not show us a risk assessment about a recent incident we had been told about. A nurse said that, in response to the incident, agency nurses no longer carried out a particular procedure. This placed additional pressure on core staff who would have to do this task for any agency nurse working in the unit.
- The ICNARC results after 2012 were not available and senior managers at the trust were not aware until we raised concerns at our announced inspection. The managers investigated and explained that there had been data problems which had delayed the data

processing and the production of the results. This meant that the trust did not have this source of information to enable senior managers to monitor their performance and help them plan future services effectively. The trust took action to obtain the information and provided us with part of the ICNARC data for 2012/13 and also for 2 January 2013 to 27 June 2013.

Leadership of service

- The critical care service was led by a matron and intensive care consultant in line with Intensive Care Society standards. However, the matron was not responsible for the MHDU. This meant that they did not have overall responsibility for all the critical care beds at the trust.
- Staff confirmed that the culture and leadership from senior managers had become more responsive. They said that senior managers were more visible in the hospital and that staff knew who they were. One nurse said that they felt "well looked after" by the trust.
- Staff said they had seen senior managers in the unit at weekends. They gave an example of how one such visit had led to the prompt provision of long awaited disposable bed curtains. They said a senior manager was now supporting the request for additional nursing auxiliary hours having seen first-hand that there was a need for this.
- Staff said there were infrequent unit meetings. A team leader said they hoped that staff would come to them as and when they needed to. A nurse said "There is always someone to turn to" and another member of staff commented that the service matron was "fair – you can go to [them] about anything at all". Another said the matron was "easy to talk to and easy to get hold of".
- The team leader was responsible for providing leadership during their shift and supporting other members of the team, particularly less-experienced and agency staff. Team leaders said that providing direct nursing care and leading the unit was challenging and meant that they were not always able to offer the level of support needed. One nurse believed that plans for future development of the unit included a supernumerary team leader on each shift.
- On 13 May 2014, the trust informed us that they responded to concerns we raised about critical care by "strengthening the leadership of the units". They moved one senior nurse and made another senior nurse "responsible to oversee some immediate transition and changes needed." However, this change did not address our concerns about the medical leadership and the general management of critical care.

Culture within the service

- One staff member said "Everyone is so supportive. People are there for each other and things always get dealt with".
- Staff in ITU/SHDU worked well together as a team and communicated with one another clearly. Staff were very busy but the general atmosphere was good and people were cheerful.
- One staff member praised their colleagues and their line manager for contributing to a positive working environment. However, they also said that a specific trust senior manager had a negative impact on the culture due to the way this senior manager spoke to staff. Several staff members stated that they did not raise concerns because they were afraid of retaliation from this senior manager.

Public and staff engagement

- A poster about the NHS Friends and Family Test initiative was displayed where visitors would see it.
- A nurse said that staff had requested additional contracted cleaning staff in the evenings for cleaning and emptying bins but were waiting to hear the outcome of this.
- Some staff said that they did not report some incidents because they did not always receive feedback about things they reported. Staff did not know who followed up or investigated incident reports or how this was done.
- Staff alleged that in recent governance meetings a trust senior manager spoke at staff, rather than with staff. Although they acknowledged relationships were improving, staff felt that the trust was still not listening to or engaging with them regarding changes to the service. They did not feel confident that the trust would adequately investigate and respond to their concerns.
- In our unannounced inspection visits, staff raised concerns about the recent unexpected change in the critical care leadership team. They said that the recent changes in critical care leadership were not explained to them and as a result they felt insecure about their own positions in the trust. Staff said they were disappointed with this change, because the critical care matron had created a positive and supportive working environment.

Maternity and family planning

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

Information about the service

In the last 12 months, Tameside Hospital NHS Foundation Trust performed over 2,500 deliveries, which was a decline from the previous year.

We visited a central delivery suite which consisted of five labour rooms, one midwifery-led birthing room, an operating theatre, a birthing pool room that was being refurbished and a bereavement room. We also visited the antenatal clinic department, a five-bed antenatal ward which was also used for recovery following surgery, and a ward which consisted of 20 postnatal beds, eight antenatal beds and a transitional care service.

During our inspection, we spoke with eight patients, four relatives, 23 midwives, five managers, five doctors, one domestic staff, one housekeeper and two maternity support workers. We observed care and treatment and reviewed performance data provided by the trust. We reviewed 12 maternity and family planning patient care records. We also reviewed records relating to the termination of pregnancy service.

Summary of findings

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for women. The service was actively involved in national and local research and audit projects. The trust engaged with women, the public and staff and acted on their feedback. The outcomes for people using the service were good compared to other services, although fewer women chose to breastfeed their babies at birth, compared to the national average. The trust had received multiple awards for providing women and those close to them the support they needed to cope emotionally with their care and treatment.

The trust's track record on safety was generally good. Women were cared for by suitably qualified staff, although sickness levels were high and the proportion of staff who had participated in mandatory training was significantly below trust targets. The trust planned and delivered its services to meet the needs of the local population, such as appointing specialist midwives or providing additional clinics. They anticipated potential risks to the service and developed plans in advance to manage these risks. They learned when things went wrong and improved safety standards as a result. However, staff did not maintain accurate records regarding consultant cover, equipment checks, or the management of aspects of controlled drug management.

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. The trust anticipated potential risks to the service and developed plans in advance to manage these risks. However, staff did not maintain accurate records regarding consultant cover, equipment checks, or the management of aspects of controlled drug management.

The trust's track record on safety was generally good. Women were cared for by suitably qualified staff, although sickness levels were high and the proportion of staff who had participated in mandatory training was significantly below trust targets.

The trust learned when things went wrong and improved safety standards as a result. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. However, some areas of the unit were in poor condition and staff did not take adequate steps to safely store or dispose of medicine.

Incidents

- The trust had an electronic incident reporting system. Staff were reporting incidents accurately and learning from incidents.
- The service had reported an increasing rate of caesarean sections (22.7%) between April 2013 and March 2014. This figure included both planned and emergency caesarean sections. In response to these findings, there was a project underway which aimed to reduce caesarean section rates by supporting more women to choose midwifery-led care.
- One serious incident had been reported regarding a maternal death. We reviewed the investigation report which included a root cause analysis. The investigating staff had identified learning which was then effectively cascaded to all staff through meetings and newsletters.
- The trust reported one Never Event (serious harm that was largely preventable) in the last twelve months. Eight members of staff demonstrated that they were aware of the incident and were able to explain how they had improved their practice to prevent similar incidents in the future. There were new safety checks in place as a result of this incident.

Safety thermometer

- The service was piloting an NHS Safety Thermometer programme that was specific to maternity. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. As this was a new programme, there was insufficient data for comparative analysis.
- In the past 12 months, 100% of patients experienced harm-free care every month, with the exception of January 2014 which was 93.7%. These results indicated that maternity services were leading the way in relation to harm-free care compared to other departments within the hospital.

Cleanliness, infection control and hygiene

- The trust used an external contractor for most cleaning duties. Some specialist equipment was cleaned by staff. Both staff and external contractors used cleaning schedules to ensure that all areas were regularly cleaned.
- All areas and equipment appeared clean and tidy. Staff practiced good hand hygiene, used gloves and aprons when required, and adhered to "bare below the elbow" policies.
- There were no hand washing facilities in the foyer of the maternity unit or at the entrance to the central delivery suite. This meant that people accessing the service could not clean their hands prior to entry.
- Some clean equipment lacked green "I am clean" stickers. This meant that staff could not easily identify what equipment was ready to use.
- The trust had no reported incidences of hospital-acquired infections, such as Clostridium difficile (C. difficile), in the maternity service during April 2013 and March 2014.

Environment and equipment

- Staff did not consistently or fully record their checks of the neonatal life support equipment in the central delivery suite. Staff said that midwives checked the equipment from their experience of knowing what is required. This meant that staff did not take adequate

steps to reduce the risks of harm from inadequately maintained equipment. We asked a senior manager to take action and were told that this matter would be resolved promptly.
- The adult defibrillator, used during resuscitation, also had gaps in its record of checks. A senior manager said that this matter would also be resolved promptly.
- While delivery rooms on the maternity unit had been recently renovated, and the birthing pool room was being renovated during the inspection, some areas of the unit were in poor condition. For example, walls were peeling, lights were broken, and skirting boards were in a poor state of repair in the midwifery-led birthing room. This made it more difficult for staff to reduce the risks of cross-infection.
- Several members of staff said that they were concerned about the maternity unit's state of repair. One member of staff said, "We feel neglected financially in maternity, other areas at Tameside get all the funding for development." Another member of staff said, "The state of the unit is why our birthing rate has dropped dramatically because women prefer the newer-looking units in Manchester; it's a shame because our care here is excellent".

Medicines
- Staff administered medicine safely.
- Medicine records were up to date and accurately completed.
- On the central delivery suite, medicines were kept in a separate locked room near the desk. However, inside the room the medicine cupboards were not locked. This meant that if the door to the room was accidently left open these medicines were not secure.
- Records for controlled drugs contained gaps in the checking history. Some controlled medicine waste was not recorded. Staff explained that they had disposed of the controlled medicine correctly; however, the records did not accurately reflect this.

Records
- The service used national standardised maternity care records that had been developed by a multidisciplinary team at the Perinatal Institute. We looked at 12 care records and found that documentation was in keeping with national guidelines and included entries from midwives, obstetricians and paediatricians. Records contained thorough patient medical histories with clearly recorded diagnoses and treatment plans.
- Staff had completed essential risk assessments, such as venous thromboembolism (VTE), or blood clots, checklists, for all 12 women post-delivery. Women deemed high risk had treatment prescribed and given.
- The service issued standardised personal child health records (also known as the red book) to parents of newborns. Staff, such as midwives and newborn-hearing screening staff, completed these appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- The trust provided staff with training on consent, the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards. Staff demonstrated adequate understanding of these subjects and the relevant legislation.
- Staff confirmed that they sought valid consent from patients before delivering care or treatment. One member of staff correctly described the process of obtaining valid consent in relation to the active and passive management of the third stage of labour. This included detailing the risks and benefits of either management.

Safeguarding
- Staff were knowledgeable about their role in safeguarding and confirmed they had received safeguarding training in the past year. Two midwives described past incidents when they had acted to safeguard people.
- There was an effective system in place which alerted staff to those patients who were considered vulnerable and required additional maternity support.

Mandatory training
- Staff said that they were up to date with their training and felt equipped to provide safe care.
- If the unit was quiet on occasions the entire team would role play an obstetric emergency. This meant that staff could practice what they had learned during their obstetric emergency training.
- Staff training records showed that only 83.94% of midwives, training midwives, doctors and support staff had participated in mandatory training. This was significantly below the trust target of 95%. Staff absence and vacancy records showed an increase in sickness and turnover over the last 12 months. Senior managers believed this was the reason they had not met their mandatory training target.

Maternity and family planning

- One junior member of staff said, "I attend study days outside the hospital where I can". However, staff shared concerns that middle-grade doctors missed out on training, due to the amount of clinical duties. Records showed that new junior and middle-grade doctors would commence employment shortly, which should free up more staff time for training.

Assessing and monitoring patient risk

- During shift handovers, staff discussed those patients who were considered high risk.
- The service had implemented a Maternal Early Warning System (MEWS) to monitor women's observations. We reviewed 12 maternity care records and found that all but two had a completed MEWS chart.
- Staff knew what various MEWS scores meant and when they should escalate a concern.

Midwifery staffing

- Women were cared for by suitably qualified staff.
- The allocation of patients to midwives took place during handovers. Staffing rotas showed that the trust took adequate steps to ensure there was a suitable skills mix across all areas.
- Staff were enthusiastic about their jobs. One member of staff said, "I love my job" and another said, "It is great here." Many staff said that they had worked for the service for several years or more.
- The trust used an established birth-rate acuity tool to determine midwifery staffing requirements. The head of midwifery confirmed that the birth ratio was within the tool's recommendation of one midwife to 32 women. Records confirmed these ratios were consistent. The supervisor of midwives to midwife ratio was also within the Nursing and Midwifery Council guidance (one to 15). National standards set out this should be 1:28.
- The trust took adequate steps to ensure that women received one-to-one midwifery care during labour.
- Sickness levels were high in maternity (7.5%) when compared to the national average (4.3%). Records confirmed that several staff had recently been on either maternity or long-term sick leave.
- When required, the service used internal bank (overtime) staff through NHS Professionals.

Medical staffing

- The maternity unit aimed for 60 hours consultant obstetrician cover weekly as per the Royal College of Obstetricians and Gynaecologists guidelines. In March 2014, weekly consultant cover was averaging 52 hours. Other monthly records showed that consultant cover was frequently below 60 hours. A senior manager said that consultants often came in to work during the weekend and that these current figures did not reflect actual hours. The manager said that they planned to record actual hours soon.
- The service sometimes used locum doctors. These were often doctors that had worked at the unit previously. One locum doctor said that they were well-supported by the trust and enjoyed working at the service.

Major incident awareness and training

- The trust had a policy which outlined planned actions in the unlikely event that the maternity unit required closure. In the past year, the maternity unit had not closed.
- Maternity services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.

Are maternity and family planning services effective?

Good

Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. The service was actively involved in national and local research and audit projects. The outcomes for people using the service were good compared to other services, although fewer women chose to breastfeed their babies at birth, compared to the national average.

The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations.

Evidence-based care and treatment

- Staff assessed patients and provided care and treatment in line with recognised guidance, and best practice standards.

Maternity and family planning

- Staff were able to cite the relevant national guidance they used in providing care, such as guidance issued by the National Institute for Health and Care Excellence (NICE) for interpreting electronic foetal heart rate readings.
- Senior managers said that the service used a combination of national guidelines, such as Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, to plan service provision. Service records reflected this.
- Prior to our inspection we received concerning information from a whistleblower about the way the service managed termination of pregnancies. We reviewed care records, policies and spoke with senior managers. This evidence demonstrated that service delivered termination of pregnancy care in accordance with the Abortion Act 1967.

Pain relief

- Staff assessed women's pain regularly and offered women a choice of pain relief when required.
- Records showed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals.

Nutrition and hydration

- There were regular meal times with a variety of food choice. Women said that they were regularly offered food and always had a jug of water beside them.
- Antenatal records confirmed that staff discussed infant feeding choices with women prior to birth. There was extensive feeding information on display throughout the service.
- Trust records indicated that 62% of women breastfed at birth in 2013/14. This was significantly below the national average (81%).

Patient outcomes

- Data from the maternity outlier surveillance programme during October 2012–September 2013 showed that the service had lower rates of maternal readmissions and perinatal mortality than expected. The trust's puerperal sepsis and other puerperal infection rates were also significantly lower than expected during this period.
- This was corroborated by other data sources, which showed that admission rates for babies from labour ward to the neonatal unit and maternal admission to intensive care were consistently below what was expected as well.
- During the last year, the service provided maternity care to 2,532 women and their babies. This birth rate had dropped by approximately 300 births from the previous year. Senior managers believed that increasing numbers of local women had opted for care offered by other, newly-renovated maternity units in the area.
- Between April 2013 and April 2014 the normal delivery rate (68%) was higher than the England average (60.7%). The elective caesarean section rate (9.9%) was below the England average (10.7%). Emergency caesarean delivery rates (13.3%) were also below the England average (14.6%). Assisted delivery rates, including both forceps and ventouse (or vacuum) delivery, were similar when compared to England averages.
- The service had numerous examples of local audits which highlighted good practice.
- The service actively participated in national research and audit projects, to improve outcomes for patients. This included research on: healthy eating and lifestyles; the quality of home visits for first-time mothers; and infant position during late stages of labour in women with epidurals.
- Senior managers said that they were planning an audit of the MEWS system for 2014/15.

Competent staff

- Staff said that they had completed an appraisal in the past 12 months. The most recent local supervising midwifery report outlined the need for a recruitment plan to maintain the "current excellent supervisor to midwife ratio" in the service. Records confirmed that applicable education programmes had already been secured with local universities for Tameside midwives.
- The trust had participated in the UK National Screening Committee's antenatal and newborn screening education audit during 2011/12. This is a tool used to assess the appropriateness, effectiveness and accessibility of educational initiatives in relation to the NHS antenatal and newborn screening programme. The trust performance was rated within expectations for all three of the audit indicators.

Multidisciplinary working

- Staff said, and we observed, that staff across all disciplines worked effectively together, both inside the hospital and in the community. Doctors said that access to medical support was good.

Maternity and family planning

- The service identified two lessons about multidisciplinary and inter-agency working from an investigation into a serious incident. Staff confirmed that this information had been cascaded throughout the relevant departments.

Seven-day services

- The service provided 24-hour telephone support for women before, during and after birth.
- The community midwifery team provided a structured antenatal and postnatal visiting programme in line with current NICE recommendations.
- The consultant obstetricians participated in an on-call rota, to ensure a consultant was available on call 24 hours a day, seven days a week.
- Between April 2013 and March 2014 records showed that an anaesthetic consultant was consistently available.

Are maternity and family planning services caring?

Good

Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. However, sometimes staff did not take adequate steps to maintain patient confidentiality.

The trust involved women and those close to them as partners in their care and treatment. Staff supported women to make informed decisions. The service had received multiple awards for providing women and those close to them the support they needed to cope emotionally with their care and treatment.

Compassionate care

- We observed positive interactions between staff, women and their families. Staff were kind and attentive to patients' needs. Patients spoke positively about staff. One patient said, "Staff are very polite and kind to me" and another said, "I am really impressed with the service from this department".
- Handover on the central delivery suite took place at the maternity desk. While this was area open to patients and visitors, staff maintained patient confidentiality by closing nearby doors and speaking quietly.
- We reviewed data from the CQC's Survey of Women's Experiences of Maternity Services 2013. The results showed that Tameside maternity service performed 'about the same' as other trusts in relation to care during labour and birth.
- Some patients (around 20) completed comments cards supplied by us during the inspection. Overall their feedback was positive. One patient described that they had a positive birth experience, they were well looked after and staff treated them with dignity and respect.
- During February 2014 a high proportion of patients who completed the NHS Friends and Family Test (which determines whether women would recommend the hospital to their friends and family) said that they were extremely likely to recommend the central delivery suite (77.8%) and antenatal unit (72.7%).
- One of the hospital's community midwives had recently won the British Journal of Midwifery's Community Midwife of the Year Award. This midwife had been recognised for supporting four women with cancer during their pregnancies. The head of midwifery said this midwife "continually goes that extra mile to support women and their families".

Patient understanding and involvement

- Women and partners were invited to take an actual tour or 'virtual' online tour of the maternity unit prior to birth. There were numerous homebirth, parenting and postnatal workshops available to support women and their partners to become involved in their care.
- Women said that they felt involved and that they understood their care and treatment.
- Staff completed antenatal, birthing and infant feeding plans in partnership with women and their families.

Emotional support

- A specialist bereavement service was provided to women and their family after the loss of a baby. This involved the provision of a private room, garden and en suite. There was a television and hot beverage facilities within the room. After being discharged from hospital, the woman's care included individualised home visits, telephone contact and annual forget-me-not remembrance services. This was organised in conjunction with a named midwife, usually bereavement trained, and the spiritual and pastoral care team.

Maternity and family planning

- Women could be referred to a consultant and specialist perinatal mental health midwife during pregnancy if staff assessed their mental health as high risk. This service aimed to meet women's emotional needs by the provision of additional and tailored care.
- In 2013, the service won the trust's chair's prize for its perinatal mental health initiative. This initiative was aimed at identifying and tackling mental health issues in pregnant women in Tameside and Glossop.

Confidentiality

- In most areas, patient boards with inpatient details such as bed allocation, were not visible to patients and visitors. However, on Ward 27, patients' full names, diagnoses and birth details were in public view behind the work station. This meant that staff did not take appropriate steps to protect patient confidentiality. We asked senior managers to take action.

Are maternity and family planning services responsive?

Good

The trust took adequate steps to ensure that women accessed its services in a timely way. Women and staff confirmed that patient flow throughout the maternity service was seamless. The trust planned and delivered its services to meet the needs of the local population, such as appointing specialist midwives or providing additional clinics. The trust took account of women's needs and wishes throughout their care and treatment and routinely listened to and learned from concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Senior managers demonstrated that they were monitoring service demand and planning and implementing services accordingly.
- There were four forthcoming midwifery vacancies, two medical vacancies and further secured funding for a smoking cessation midwifery post.

Access and flow

- In pregnancy, women visited their GP who referred them to the maternity service. Between April 2013 and March 2014, the trust booked 91% of women into the service before their 13 weeks gestation.
- Women and staff confirmed that patient flow throughout the maternity service was seamless. One person said, "I saw a midwife as soon as I was admitted, I didn't have to wait". Staff assessed women on the antenatal ward and were either discharged or admitted to other areas within the service.
- The bed occupancy rate for maternity (44.3%) had been consistently below the national England average (58.6%).
- In the last 12 months, the length of stay for women post-delivery had been approximately two days. Women and staff said that patients were welcome to stay on the postnatal ward until they were ready to go home. This meant that the trust discharged women at a time that suited their needs.

Meeting people's individual needs

- The trust gave pregnant, low-risk women the option of delivering their baby in hospital or at home. During the past year 2.54% of women who booked at Tameside had a home delivery.
- In hospital, the service also offered women the choice of a midwifery-led birthing room service. Staff said that the birthing room would be updated to provide a non-clinical, home-from-home environment for low-risk labouring women.
- During our visit the trust was refurbishing the birthing pool room so it was not in use. Instead, women used inflatable birthing pools. This meant that the trust took action to ensure they offered a range of choices to women, regardless of the refurbishment of the unit.
- The service had a variety of mobilisation aids to support birth and aid comfort. This included mats, a National Childbirth Trust birthing bed, piped gas and air and birthing balls. However, most of the service's birthing balls were too small to be effective birth aids for most women.
- In response to Tameside's high teenage pregnancy rates, the service had developed, within their own resources, a teenage pregnancy service. This initiative included creating a more teen friendly environment in hospital, ensuring more continuity of care from staff in the maternity services and developing a specialist teenage

pregnancy midwife role. In 2011 the service won a CBI People Award for Value in the Public Sector for the success of this service. Data showed that the number of teenagers who were expecting their second child had reduced.
- In response to high levels of obesity and smoking, the service appointed a specialist smoking cessation midwife and provided an obstetric-led clinic to support women with obesity.
- The service provided women and visitors a range of supportive health education literature including leaflets and posters. Staff said that most leaflets could be adapted into alternative languages.
- There was a translation service for women with limited English proficiency available 24 hours a day. This involved a translator attending the woman's side. Staff commented that this service was reliable. In addition, staff could access an interpreter via the telephone.

Learning from complaints and concerns

- There were posters displaying how to make a complaint and comment boxes in most areas. Comments were regularly reviewed and where possible were acted on to improve the service.
- Complaints that the maternity service had received in the past 12 months were handled effectively, within appropriate timescales and in line with trust policy.
- Senior managers and staff were open and transparent about the complaints the service had received and how they had been managed. Minutes of a staff meeting included learnings from recent complaints.
- One manager said that they had received a few complaints about the visiting times being too restrictive on Ward 27. The service had responded to these concerns by extending visiting times.
- The trust's review of the Patient Advice and Liaison Service (PALS) and complaints between April 2013 and March 2014 stated the Womens & Childrens division had received 138 complaints.

Are maternity and family planning services well-led?

Good

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for women.

The trust took adequate steps to learn continually, improve and ensure the future sustainability and quality of care. The governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks.

The leadership and culture within the organisation reflected its vision and values and promoted the delivery of high-quality care across teams and pathways. Staff said that managers were visible, accessible and approachable. The trust engaged with women, the public and staff and acted on their feedback. However, some information about the safety of the service was presented in a way that may have been difficult for people to interpret.

Vision and strategy for this service

- Staff had a clear understanding of the trust's vision, values and objectives, which were displayed throughout the service.
- The trust developed its service improvement strategy by measuring the service against key objectives.
- In response to the decrease in the number of midwifery-led deliveries, the service reinforced its aim to promote midwifery-led care by developing a new antenatal pathway and renovating the midwifery-led birthing unit.

Governance, risk management and quality measurement

- Incidents, complaints and audits were analysed and reported through the governance team to the board.
- The trust monitored the service using a maternity safety dashboard. The dashboard was colour coded (green, amber and red). If an area was highlighted at risk, it was displayed 'red' which alerted those scanning the dashboard. This enabled the governance team to take action, such as improving incident reporting rates.

Leadership of service

- Midwives and doctors said that leadership within each unit was good and that they felt well-supported by senior staff.
- Leaders within the service celebrated staff success. The service maintained a 'wall of achievement' which displayed all the awards the service had received. A senior manager said that they were very proud of staff achievement and wanted to share this with patients and visitors.

- Staff had access to newsletters in numerous staff areas which demonstrated the senior leaders disseminated learning, such as updates from the Trust Board.
- Staff said that Trust Board members were visible and approachable and had led positive change within the trust. One member of staff said, "Tameside has improved dramatically since the new chief executive has come into [the] role".

Culture within the service

- We observed clear mutual respect between staff and across disciplines. Staff were motivated, proud and enthusiastic about their job. One staff member said "I love my job" and another said, "I wouldn't work anywhere else". Such comments were consistent throughout the service.
- Staff were clear of the successes at the service but also aware of areas that required improvement. A manager said, "We are always looking at ways to make our service even better here". This meant that staff acted to ensure service improvement.
- The trust had whistleblowing and maternity escalation policies. Staff described examples of issues they had raised in the past and how management acted swiftly and effectively in response.

Public and staff engagement

- The trust displayed the Safety Thermometer findings on a public-facing board on Ward 27. However, the information displayed was complex and some women and visitors may have had difficulty interpreting it.
- The trust maintained a variety of ways that the public could provide information about their experiences, such as online feedback forms and comments boxes.
- Staff said they were invited to monthly unit meetings. They said that this was an opportunity to give feedback and discuss issues about the services.

Innovation, improvement and sustainability

- A senior manager said that, although they had been declined funding for renovation of the entire maternity service, they were awaiting confirmation for funding to develop the antenatal clinic.
- In 2012, the maternity unit launched a fundraising campaign called the Bright Start appeal. This campaign had funded the development of the birthing pool room and would fund the development of the midwifery-led birth room.

Services for children and young people

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

Information about the service

Children's services at Tameside General Hospital included a children's ward, an observation and assessment unit, outpatients, a neonatal unit and an extensive range of children's community health services. The children's ward provided 24-hour care to children and comprised a 21-bed inpatient unit, eight-bed day case unit and a dedicated resuscitation and stabilisation area for higher dependency care.

The neonatal unit had just over 270 newborn babies admitted each year. It provided short-term intensive care, high dependency care and special care for babies within the north west neonatal network. The service was a local level 2 unit, which meant that babies who were less than 27-weeks' gestation, or who were very sick, required transfer to a tertiary neonatal unit for longer-term intensive care. The North West Neonatal Transport Service provided a dedicated service if a baby needed to be transferred to an alternative unit.

During our inspection we spoke with 12 children and their parents, seven doctors, five nurses, three managers, a support worker and a cleaner. We reviewed 10 patient records from across the service. We observed interactions between staff, children and parents. We reviewed records relating to the management of the service.

Summary of findings

The trust paid attention to detail when designing the service appearance and facilities, which catered for all ages of children and young people. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. Children, young people, parents and carers praised the caring approach of staff. The service learned when things went wrong and improved safety standards as a result. However, the service's proportion of staff whose had completed their mandatory training was below trust targets. Some potential and relatively minor risks to the service had not been anticipated or planned for in advance, such as access to the neonatal unit which although security was in place it could be improved . Staff were not consistently checking neonatal resuscitation equipment and storage of controlled drugs. The outcomes for people using the service were generally good.

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for children and young people. The trust engaged with children, young people, families, the public and staff, seeking and acting on their feedback to improve the quality of the service. Staff worked closely with external agencies to ensure that care delivery was seamless and tailored specifically to individual needs. The culture within the service reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and

Services for children and young people

pathways. The leaders of the service particularly encouraged staff to be innovative, caring and cooperative. People's comments and complaints were catalysts for service improvement.

Are services for children and young people safe?

Requires improvement

In most areas the services being delivered to children and young people were safe. The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. Some potential risks to the service had not been anticipated or planned for in advance, such as access to the neonatal unit. Staff were not consistently checking neonatal resuscitation equipment and controlled drugs.

The service learned when things went wrong and improved safety standards as a result. There were reliable systems, processes and practices in place to keep children and young people safe and safeguarded from abuse. However, the service's proportion of staff whose had completed their mandatory training was below trust targets.

Incidents

- There were no Never Events (serious harm that was largely preventable) reported for this service in the last year.
- The trust had an electronic incident reporting system in place. Staff said they could access the hospital's incident reporting system and understood their responsibilities in regard to this.
- The service held regular monthly children's clinical governance, perinatal and mortality and morbidity meetings. Records showed that these were well attended. Staff said that this was an opportunity to learn and discuss complex cases and incidents.

Safety thermometer

- Children's services were not using a Safety Thermometer at the time of our visit; however, staff said that there were plans for the service to implement this soon.

Cleanliness, infection control and hygiene

- During April 2013 and March 2014 the children's service reported no incidences of hospital-acquired infections, such as Clostridium difficile (C. difficile).
- The children's service was clean and tidy. Measures were in place to ensure patients were protected from the risk of infection.

- The trust had sufficient cleaners throughout the service, suitable cleaning schedules and appropriate systems in place for cleaning and decontamination of equipment.
- Not all clean equipment had the "I am clean" green sticker applied and this made it difficult for staff to determine what had been cleaned.
- Staff were compliant with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately and wore their uniforms above their elbows.

Environment and equipment

- The environment was bright, clear of clutter and well organised.
- Records for the neonatal life support equipment on the neonatal unit indicated that staff had not regularly checked it. There were gaps in the checking history and a lack of audit evidence. This meant that staff did not take adequate steps to reduce the risks of harm from inadequately maintained equipment.
- In other areas in children's services, records showed staff checked equipment regularly.
- Although access from outside was secure, the door entry system to the neonatal unit did not have a buzzer or keypad entry system. We raised concerns with the trust that people from the maternity unit such as visitors and or high-risk patient groups, could walk freely into this service. The trust said they would take action.

Medicines

- Medicines, including controlled drugs, were safely and securely stored in all wards and departments. Staff administered medicines safely. Records demonstrated that staff prescribed and administered medicines safely.
- Records indicated that staff did not consistently check controlled medicines. During April 2014 on one unit there were 16 days where controlled drugs were not checked. Staff confirmed that these medicines should be checked at least once daily. This meant that staff did not take adequate steps to ensure the safe management of medicines.

Records

- The trust stored records securely.
- We reviewed 10 patient records. The documentation was of a high standard, with legible notes, and in line with best practice guidance. Each child had a thorough history recorded, as well as further assessments of their risks and needs, a diagnosis, and a treatment plan. The records reflected the holistic needs of each child.

Consent

- The trust provided training on consent, the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards to all staff. Staff demonstrated adequate knowledge about the subjects and applicable legislation.
- Staff obtained patient and or parental consent in a legal manner. Training records confirmed that 100% of doctors had completed consent competency training.
- The trust had appropriate policies in place in relation to consent to treatment in children. Staff were knowledgeable about Gillick competence and Fraser guidelines. These guidelines are tools used to assist professionals in determining whether a child is mature enough to make their own decisions about care and treatment.
- There were appropriate forms for obtaining written consent.

Safeguarding

- The trust had an infant abduction prevention policy in place.
- There were up-to-date children's safeguarding policies and procedures in place which incorporated relevant legislation. Records demonstrated good safeguarding practice.
- Staff were knowledgeable about their role in safeguarding and confirmed they had received safeguarding training in the past year. Training records indicated that 93% of staff were compliant with safeguarding training. This compliance rate had improved greatly since March 2014 (76%).
- There was a team dedicated to children's safeguarding. They had undertaken significant work around provision of safeguarding supervision within the department and demonstrated that they worked effectively with other children's services, including the local authority. Staff said that the safeguarding team were highly visible, effective and encouraged them to attend regular safeguarding meetings.

Mandatory training

- Some units' training records demonstrated high levels of mandatory training compliance. In the neonatal unit,

compliance was above 95%. Overall, however, only 79.57% of all children's staff were up to date with their mandatory training. This was significantly below the trust target of 95%. This meant that there were not suitably skilled or trained staff on duty at all times.

Assessing and monitoring patient risk

- There were appropriate systems to assess and monitor patient risk. The service had implemented a Paediatric Early Warning Score (PEWS) system. When completed, this tool generates a score through the combination of a selection of routine patient observations, such as heart rate. This tool was developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- We reviewed patient records and found evidence that staff completed these charts accurately. Staff explained what various scores meant and when they would escalate a concern. There were clear directions for escalation printed on the reverse of charts for staff to reference. Staff used the tool effectively.
- During shift handovers, paediatric doctors made clinical decisions about a patient with reference to their increasing PEWS score.
- Only 45% of children at the trust were seen by a middle-grade or consultant paediatrician within four hours of admission. The UK average was 77%.

Nursing staffing

- During our visit we observed that there was a sufficient number of trained clinical, nursing and support staff with appropriate skills on duty to ensure safe and effective care.
- A paediatric acuity tool had been used to determine and ensure safe staffing levels throughout the service. For example, in the neonatal unit, the manager said that staffing establishment was calculated using an acuity tool alongside the British Association of Perinatal Medicine guidelines.
- Staffing records, however, demonstrated that, on some shifts, the trust did not have optimal staffing numbers. Managers said that nursing recruitment had been a challenge within the department.
- The service used bank (overtime) nursing staff via NHS Professionals if required. Staff said that this was an effective system.

Medical staffing

- There was a sufficient number of junior and middle-grade doctors on duty to ensure safe and effective care. Consultants were available 24 hours a day.
- Doctors spoke positively about the support they received from peers. One middle-grade doctor said that they were "incredibly well-supported by seniors" and that their training was of a high standard. A junior doctor said, "The word amongst trainees is that Tameside is the best place to come for training placements" in children's services.
- Handover between medical staff was well-structured and well-attended. It provided an opportunity for staff to discuss clinical decision making.

Major incident awareness and training

- Children's services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.

Are services for children and young people effective?

Good

Staff assessed people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. The outcomes for people using the service were generally good. However, rapid access to medical assessments was significantly worse than other services.

The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations. The service took adequate steps to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment. However, the proportion of staff who had a recent appraisal was below the trust's target.

Evidence-based care and treatment

- Trust policies and care records showed that patient assessments and treatments were provided in line with recognised guidance and best practice standards.

- Staff demonstrated evidence-based care, such as a doctor prescribing treatment to a baby for neonatal jaundice in line with current neonatal jaundice guidance issued by the National Institute for Health and Care Excellence (NICE).
- Medical staff confirmed that they were familiar with local neonatal and paediatric protocols, and when faced with a new challenge said that they could access necessary electronic protocols, information and support promptly.
- Many policies did not have a visible review date. This meant that staff could not easily identify if the policy was up to date.

Pain relief

- Children appeared comfortable and parents said that their child's pain levels had been regularly assessed and effectively managed.
- Staff used child-friendly pain charts to help children to describe any pain they were experiencing.
- Medication charts confirmed that staff administered pain relief to children as prescribed.

Nutrition and hydration

- Staff met patients' nutrition and hydration needs. Children had access to drinks. There were regular meal times with a variety of food choices. Patients' records included completed fluid charts.
- On the neonatal unit, staff supported new parents with infant feeding choices. There was extensive feeding information on display encouraging breastfeeding and a newly renovated breastfeeding room. Formula and breast milk were in date and stored safely.

Patient outcomes

- The trust's mortality outlier data demonstrated no evidence of risk in relation to paediatric congenital disorders and perinatal mortality. (A mortality outlier is a service that lies outside the expected range of performance in regards to mortality.)
- The number of neonatal readmissions was similar to expected.
- The service had achieved all the key performance indicator targets it had set from January 2014 to March 2014. In one month 98% of inpatient discharge letters were sent within 24 hours following discharge from hospital. This was above the 95% key performance indicator target.
- The children's community nursing team had conducted an audit of their services. The team identified that 50 children had been rapidly responded to in the month of February 2013. We observed the results and found that 90% of parents and children were satisfied with the rapid response service and that, after a child had been seen and referred to the team, the family was contacted by telephone in good time and a home visit arranged.
- The service had participated in the following national paediatric audit programmes: Child Health Programme (Child Health Reviews UK); Diabetes (Paediatric) (National Paediatric Diabetes Audit); Paediatric Asthma and Paediatric Pneumonia (British Thoracic Society); Paediatric Fever (College of Emergency Medicine).
- The service had also participated in The Royal College of Paediatrics and Child Health's Back to Facing the Future 2013. This was a national audit of acute paediatric service standards. The audit highlighted areas for improvement within the service.
- Since the publication of Back to Facing the Future the service had commissioned the 24-hour opening of the observation and assessment unit. Consultant paediatricians and managers said that, due to these changes in opening times, they were certain that the standards had significantly improved. Staff were unable to show us the latest audit data due to difficulties with the new electronic records system.
- Trust data indicated that a significantly higher proportion of children were using the observation and assessment unit since the new opening times. Patient feedback demonstrated that the vast majority of parents and carers were "happy" with the time they waited for their child to be seen by a doctor.

Competent staff

- Training records showed that 84% of all staff had received an appraisal in the past year. This was below the trust's target (90%). Senior managers were aware of this concern and were acting to improve compliance.
- Middle-grade medical staff said they were well-supported and had regular supervision. One doctor said, 'It's the best job I have had so far because there is a lot of consultant presence and I feel well-supported'.
- Nurses said they felt well-supported in their role.

Services for children and young people

Multidisciplinary working

- There was effective multidisciplinary working. Parents said that the various children's services they had experienced worked well together. Records and observations of care confirmed this. We tracked the case of one child with a complex medical history and found that staff coordinated care effectively with other disciplines, including a dietician and a GP.
- Records demonstrated effective inter-agency working, including social services.
- Staff could access psychiatric input for children when required. An overdose pathway detailed contact numbers for emergency referrals to the local Child and Adolescent Mental Health Service (CAMHS). This was available 24 hours a day.

Seven-day services

- Consultant staffing rotas showed there was a consultant on call at all times every day. Staff confirmed that consultants always led the weekday ward rounds.

Are services for children and young people caring?

Good

Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. Children, young people, parents and carers praised the caring approach of staff. The trust involved people who used the service and those close to them as "partners' in their care and treatment.

Staff supported children and young people, where appropriate, to make informed decisions. Staff provided children, young people and those close to them the support they needed to cope emotionally with their care and treatment. The inpatient survey results demonstrated that the staff were consistent in providing compassionate care and emotional support.

Compassionate care

- Children and parents said that staff went out of their way to be caring. Our observations confirmed this. We saw a nurse walking down a corridor with a child, holding their hand and smiling. Staff of all grades spoke appropriately and kindly with children.
- One parent said, "Staff are amazing" and another said, "Staff are very caring and helpful here".
- Parents had a dedicated lounge within the children's ward where they could make themselves refreshments.
- The results from the observation and assessment unit survey from January – March 2014 showed that 100% of the parents and carers stated that they would be extremely likely or likely to recommend the service to friends and family, that staff were always friendly, that they had understood answers to questions they had asked and that staff kept them well-informed about care. Comments included, "Five stars!" and "Thank you very much for the excellent care and warmth we received today".
- External feedback sources such as the NHS Choices website and the Patient Opinion survey confirmed that compassionate care was consistent. One person said, "Thank you so much for the wonderful care" and another person said, "Brilliant care on the children's ward". Of the 14 people who had left comments on the Patient Opinion website, 13 described a positive experience.

Patient understanding and involvement

- Patients and children said that they felt involved and understood care and treatment. Staff discussed care plans with children and parents.
- Literature displayed on the wards and on the trust's website demonstrated that the service actively encouraged those responsible for children to be involved in their child's care and welfare.

Emotional support

- There was a range of emotional support available for children and young people. The dedicated play team of five staff endeavoured to ensure that children were supported with psychologically-grounded play, to prepare and distract them before surgical and medical procedures. This included pre-operational clinics and blood tests. Their aim was alleviate children's anxieties. We observed the play team's interactions with children and found that the children responded well.
- The trust designed the environments purposefully to distract and entertain children during their stay by brightly painting doors. Children's movies were provided on bedside televisions. Children had access to exceptional play rooms, filled with age-appropriate toys, at all times.

Services for children and young people

- The trust welcomed parents to stay the night with their child. Some children's rooms contained fold-out beds.

Are services for children and young people responsive?

Good

The trust paid attention to detail when designing the service appearance and facilities, which catered for all ages of children. The trust planned and delivered its services to meet the needs of different people. Staff in the children and young people's service clearly understood the needs of the local community and had developed effective specialist services accordingly. The trust took adequate steps to ensure that people accessed its services in a timely way.

The service took account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge and at transitions. Staff worked closely with external agencies to ensure that care delivery was seamless and tailored specifically to individual needs. The trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care. People's comments and complaints were catalysts for service improvement.

Service planning and delivery to meet the needs of local people

- The trust completed its Health Investment in Tameside (HIT) project in December 2010 which involved comprehensive restructuring of the hospital, including a new state-of-the-art integrated children's unit. Local people participated in the planning phase.
- The trust undertook a large-scale consultancy project prior to the service restructure. This resulted in changes to the plan, to reflect the views of local primary school children, staff and patients.
- Every age of child had been considered. On the children's ward, cubicle curtains had been designed by one of the managers and at night the colourful giraffe pictures reflected silhouettes on the floor, corridors looked like gardens with painted grass and flowers, there was an atrium with a giant, child-friendly statue, an adolescent room with electronic games and air hockey, a younger child play room and a sensory room which could be used by babies and children with additional needs.
- The outcome of this restructure meant that the service did not look like a hospital through the eyes of a child. One child said, "I don't want to leave, it's so much fun here".
- Beyond the aesthetics, the trust tailored service design to meet local children's health and social needs. There were dedicated children's diabetes, paediatric epilepsy, community nursing and safeguarding teams, developed due to service demand.
- The service had a close working partnership with the local children's trust which aimed to integrate and develop children's services within Tameside through agreed, shared objectives.

Access and flow

- Patients accessed the children's ward, observation and assessment unit and outpatients department services via the accident and emergency department or by referral from a GP and other healthcare professionals.
- Patients, parents, staff and our observations confirmed that patient flow throughout the service was seamless.
- Bed occupancy rate throughout the service was below national average. In the neonatal unit, the bed occupancy rate was 55.6% whereas the national average was 71%. On the children's ward, the average length of stay was consistently below the expected threshold (1.5 days). For example, in April 2014 the average length of stay was 1.2 days.

Meeting people's individual needs

- A community nursing team based in the children's ward provided care to children locally. This aimed to provide care "closer to home" while reducing hospital admissions. Records indicated that there had been a significant reduction in hospital admissions because of this service. Parents, children and carers fed back positive comments about the community nursing team.
- Dedicated specialist teams provided care and emotional support to children with varying medical needs. A paediatric epilepsy service consisted of a consultant paediatrician with special interest in epilepsy, a paediatric epilepsy specialist nurse and a paediatric neurologist. There was a well-established paediatric diabetes team. This meant that the care children received was tailored and specialised to their individual needs.

Services for children and young people

- The service had welcoming display boards that greeted patients and visitors in various languages. There was interpreter available for children and parents who were not proficient in English. Staff could obtain health education leaflets in various languages as required.
- The trust offered a range of meals to suit varying cultural needs.
- A specialist medical service was available for the management of children with specific vulnerabilities, such as learning disabilities. Records showed that the service worked well with the local multidisciplinary Integrated Service for Children with Additional Needs which provided treatment and support to children with disabilities or complex health needs.

Learning from complaints and concerns

- Complaints were handled effectively, within appropriate timescales and in line with trust policy. We reviewed the formal complaints that had been received. Records confirmed that the service responded to 100% of complaints within 25 days. Senior managers said that they personally try to meet with complainants to resolve any issues immediately.
- The trust had a visible complaints process. There were posters displaying how to make a complaint and comments boxes in ward areas. Boards in public areas displayed patient feedback from inpatient surveys as well as data on complaints. Managers said that they reviewed these comments regularly and always acted to improve the service where possible.
- The service demonstrated that they learned from complaints and concerns. Concerns from parents had recently been received about the lack of community nursing outpatient clinic appointments during the evening and weekend. In response to this, staff said that there was now a Saturday morning and weekday evening clinic available.
- A senior manager said that there had been an isolated incident regarding treatment of a newborn infant without parental consent. Staff demonstrated that they learned from this incident.
- The trust's review of the Patient Advice and Liaison Service (PALS) and complaints between April 2013 and March 2014 stated the Womens & Childrens division had received 138 complaints.

Are services for children and young people well-led?

Good

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for children and young people. The governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks. However, the trust did not take adequate steps to cascade vital information about incidents, complaints and achievements to all staff. This meant that there were missed opportunities for staff to improve individual practice from lessons learned.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The trust engaged with children, young people, families, the public and staff, seeking and acting on their feedback to improve the quality of the service. The service took adequate steps to learn continually and improve, to support safe innovation, and to ensure the future sustainability and quality of care. The leadership in the service particularly encouraged staff to be innovative, caring and cooperative.

Vision and strategy for this service

- The trust had a clear vision and strategy with identifiable aims and objectives. The trust vision, values and objectives had been disseminated throughout the service. Staff had a clear understanding of these aims and objectives.
- Locally, the service had its own vision for further development and improvement. Senior managers said this included adapting current ways of working to increase the number of children seen at the observation and assessment unit. This aimed to take pressures off of other departments such as accident and emergency.

Governance, risk management and quality measurement

- The service had systems in place to identify, monitor and manage risk effectively. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the governance team then escalated

to the board. The records of incidents reported within children's services demonstrated that the service learned from reported incidents. This system was robust and effective.

- The trust held children's service governance meetings monthly. This was an opportunity to identify risk and drive improvement across the service. However, staff could not demonstrate awareness of current complaints, incidents and achievements within the service and could not describe how they would find this information out.
- The service undertook a range of local and national audits. The local audits included infection control audits and an audit on children's fever. This meant that the trust was actively monitoring the quality of its service.
- The service measured service quality through an indicator dashboard. This indicated elements of risk within the service. The dashboard was colour coded (green, amber and red). If an area was highlighted 'at risk' it presented in red which alerted those scanning the dashboard. No areas had been rated red in the past three months. Staff said the service would be implementing a more extensive safety dashboard soon, in line with other services in the trust.

Leadership of service

- Senior managers were dedicated, enthusiastic and inspiring. The managers of each unit demonstrated clear leadership principles and the trust values. Staff spoke highly of their seniors. They said that they felt respected, valued and well-supported by managers. Staff said "Senior managers are consistently visible and accessible" and "fantastic".
- Staff of all grades spoke positively about the new Trust Board members and were clear that these new senior leaders had driven effective change throughout Tameside General Hospital. One member of staff said, "There have been vast changes, good changes and the new chief executive has been a huge catalyst for this success".

Culture within the service

- Staff were very open and honest with inspectors. They said what worked well and what did not work as well. Staff said they would raise concerns with managers if necessary, in line with the trust's whistleblowing policy, and they felt that they would be listened to. Staff gave examples of when they had done this and how managers had taken appropriate action.
- There were positive ethos and mutual respect between colleagues. Staff throughout the service said that they were passionate about their job, felt respected by peers and enjoyed working within the children's services.

Public and staff engagement

- An inpatient survey of people was conducted monthly in each area.
- The service had a variety of ways the public could engage with the service, including electronic tablets and comments boxes. Posters on noticeboards encouraged public engagement.
- The trust involved staff in service restructure and invited them to monthly unit meetings. Managers said these provided an opportunity for staff to discuss any issues. Staff said that they were "very much involved" in redesign projects, most recently renovation of the neonatal unit.

Innovation, improvement and sustainability

- The children's community nursing team had developed an existing dependency tool which determined patient risk via a colour rated scheme. Patients highlighted red were those who were clinically unwell or at risk of requiring hospital admission, observation or assessment. By acknowledging these risks, the service could prioritise care and plan staffing capacity accordingly. Records demonstrated that, since the implementation of this tool, the number of children requiring hospital admission had decreased.
- The neonatal unit had recently been renovated. The area was clean, bright and very tidy. Staff were proud of their new unit. One staff member said, "We function better now as everything is highly organised and we have more space".
- Nursing and medical staff discussed innovative training methodology used in the trust. A nursing manager described how they had designed and implemented a paediatric update study day, which covered recognition of the deteriorating child, necessary investigations and effective discharging planning.

End of life care

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

Information about the service

End of life care at Tameside General Hospital was provided throughout the wards and departments. There was no designated oncology or palliative care ward or area. There was an end of life care team which consisted of an end of life facilitator, specialist cancer care nurses, seven Macmillan nurses and at least one palliative care link nurse on each ward. There were working links with a local hospice whose palliative care consultant telephoned the hospital most days and visited at least twice weekly to give support, advice and training. Marie Curie cancer care nurses provided out-of-hours support and a rapid discharge service. Staff at the local hospice provided a telephone advice line.

During this inspection we visited wards 30, 41, 43, 44, 45, 46, accident and emergency (A&E), medical assessment and admissions unit, chaplaincy service and the mortuary. We spoke to three relatives, 24 nursing staff of various grades, one Macmillan nurse, the lead chaplain, the mortuary manager, the end of life care facilitator and the cancer services manager. Due to the sensitive nature of this area of care, it was not possible to speak directly to patients or relatives regarding the specific end of life care. We observed interactions between staff and patients, reviewed 12 patient records, and read policies and procedures and other documentation as necessary. We heard patient and carer experiences of end of life care at the listening event and reviewed data provided by the hospital.

Summary of findings

The trust was in the process of developing its end of life care service, pending the release of revised national guidance following changes to best practice guidance. As a result, some staff felt less confident about providing effective care for patients at the end of life.

There was good provision for out-of-hours support from palliative care specialists, however, not all staff were aware of how to obtain it.

The trust had improved the way staff took account of people's needs and wishes at the end of their lives, including at referral, admission, discharge and at transitions. The mortuary provided a respectful and dignified service to the deceased patient and their families.

There were inconsistencies in how staff implemented policies or guidance. Information on the outcomes for people using the service was limited.

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for people. There had been changes to the senior management team in end of life care which raised the profile of end of life care within the trust. The trust took adequate steps to learn continually and improve, such as providing syringe drivers to promote rapid discharge for patients who wish to die at home. They supported safe innovation to ensure the future sustainability and quality of end of life care, such as working with other local trusts to develop an advanced care plan.

End of life care

Are end of life care services safe?

Requires Improvement

The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. The trust learned when things went wrong and improved safety standards as a result, such as implementing new policies. However, staff reported and records showed inconsistencies in how staff implemented the policies or guidance.

There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse. However, staff did not follow guidance regarding the safe management of controlled drugs. There were not adequate systems in place to manage medications.

Incidents

- There had been no Never Events (serious harm that was largely preventable) linked to end of life care in the last year.
- The end of life facilitator attended the trust discharge action group meetings every Monday. Staff discussed learning from patients' discharges at this meeting which were taken back to the relevant department to ensure actions were taken when necessary.

Cleanliness, infection control and hygiene

- The mortuary was clean and tidy in all areas, including the viewing areas.

Environment and equipment

- The trust had acquired three syringe drivers specifically for patients who required these to be in place prior to discharge. These were stored in the discharge office for use out of hours, to avoid the need to delay a patient's discharge due to a lack of this vital equipment. Staff said these had been used to good effect, when patients would otherwise have had to wait for the equipment to be available in the community.

Medicines

- Staff prescribed medication in anticipation of a patient requiring it, to increase their comfort, at the end of their life. This medication included pain relief, sedation and medication to reduce airway secretions. This meant staff could ensure a patient was comfortable if their condition rapidly deteriorated.
- For one patient who was receiving pain relief in the form of a liquid controlled drug, there had been an occasion when this was not available on the ward. In the controlled drug register it was recorded that 15mls had been "borrowed" from another ward.
- The reason the medication was out of stock was due to the order not being delivered from pharmacy in the accepted timescale of "same day". However, the medication had not been ordered promptly when the stock was reduced. This meant that staff did not ensure essential medication was available for patients.
- On one ward we saw an incident recorded where a patient had to wait for their pain relief on two occasions. The first time was "due to an emergency on the ward" and the second time (the nurse) "was unable to leave another patient so (the patient) was waiting". This meant that this patient did not receive adequate pain relief, in a timely fashion, to keep them comfortable and pain free.

Records

- We looked at the records of 12 patients who were receiving end of life or palliative care. These were medical and nursing records, including care charts and medication administration records.
- Records were stored in closed cabinets in staff areas.
- In one of the patient's records there was no plan for pain management, although the hourly rounding chart showed this patient had been in pain and was receiving pain relief.
- The DNA CPR policy had been changed in March 2014 in response to concerns raised at our previous inspection in January 2014. The new policy defined the frequency of review for a DNA CPR decision.
- The trust's policy states an "indefinite" decision can remain unless "there are improvements in the person's condition." We saw for one patient a DNA CPR order was recorded as 'indefinite', however, they were deemed to be "stable for discharge" from 3 April 14 due to improvement in their condition. For this patient, there was no record of discussion with them or other relevant people with regard to the DNA CPR order. This meant the patient and those close to them were unaware of this decision and it had not been reviewed when the patient's condition improved.
- Doctors said that, according to the new trust policy, only consultants could now specify that a patient's DNA CPR order would last "indefinitely". On the "indefinite" orders

we reviewed, the consultant had made the decision or had reviewed a decision made by a more junior doctor within 24 or 48 hours. This meant senior clinicians were involved in DNA CPR decision making for all patients where the order was deemed to be "indefinite."

- Two patients in the combined intensive therapy and surgical high dependency unit (ITU/SHDU) who had DNA CPR forms in place had been resuscitated. This meant that information regarding decisions about resuscitation orders was not adequately communicated, resulting in staff not acting on people's wishes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff members understood the need to gain consent for care and medical interventions. They discussed how they would do this verbally for daily care interventions, such as assisting with personal hygiene. We heard staff asking patients if they could assist them, for example, to have a wash.
- Staff respected the decisions of patients receiving palliative care who had the capacity to make decisions regarding their care and treatment. An example of this was a patient who had requested to be moved into the main ward from a side room. This had been carried out as soon as possible.
- One patient had a wish to return home while others involved in their care thought a hospice placement would be more beneficial. Staff discussed these differing views and arranged a best interest meeting.
- Records for other patients demonstrated that staff had arranged multidisciplinary meetings to discuss the patients' best interests. For one patient, the multidisciplinary team meeting consisted of the staff nurse, Marie Curie discharge coordinator, the occupational therapist, doctor, social worker and family members. This showed that staff understood the need to support people to make decisions regarding their care and treatment at the end of their lives.

Safeguarding

- Staff were aware of the whistleblowing policy and how to report any concerns they had regarding risks or suspicions of abuse.
- They spoke about a "transparency" on the wards and in the trust more widely which contributed to them discussing any concerns with their line manager, if appropriate, or in escalating concerns if their line manager was implicated.

Mandatory training

- The mortuary manager said that induction training now covered basic information regarding care at the end of life. They invited new employees throughout the hospital to the mortuary to help them understand how they cared for a person after death.
- Further training in the care of people at the end of their lives was not mandatory at the trust.
- The majority of ward staff had not received training in end of life care. Some qualified nurses said they had not done this since they had trained initially which was "years ago." This meant staff may not have the up-to-date knowledge and skills required to competently care for patients at the end of their lives.
- There were bi-monthly education sessions for the end of life link nurses. These consisted of speakers attending to cover various topics. This included the consultant and a nurse from a local hospice who provided training regarding the nursing and medical needs of patients.
- Staff said these link nurses would then cascade this training to others on the ward, however, this was at an early stage. On the wards we visited there was no system in place for this training to be disseminated.
- Doctors and nurses said the palliative care consultant from the local hospice was very helpful in providing guidance and training in all aspects of end of life care. One doctor who had recently attended this training said it had been helpful.
- The end of life care facilitator said specific training regarding communication was to take place in the near future. This would include foundation-level training for most clinical staff and advanced training for six staff members.
- The trust had secured funding for two general practitioners and two medical staff to complete their diploma in palliative care. A Macmillan nurse praised how well they had been supported by the trust to complete their degree in palliative care.
- Five nurses had completed training to use the multi-professional toolkit which was designed as a recording tool in the absence of the Liverpool Care Pathway (a care pathway for delivery of end of life care, no longer used, in accordance with national guidance). Staff were unaware when this training would take place for them.

End of life care

- Nurses said they had received training in the safe use of the syringe drivers. Some said they would require further guidance if they were required to use one; however, they all said there was "always someone to ask who would help."

Assessing and responding to patient risk

- Staff said that, in line with national guidance, the Liverpool Care Pathway for the management of people requiring end of life care was no longer being used in the hospital. It had been replaced with the NHS England Principles of care and support for the dying patient. Staff said they would follow these guidelines if a person's condition deteriorated.
- Staff said if a person's condition worsened in any way they would get the support of more knowledgeable staff in the form of Macmillan nurses, Marie Curie cancer care nurses and the palliative care team at the local hospice.

Nursing staffing

- Staff said if they had a patient who required additional staff time, due to deterioration in their condition, they could ring other wards and ask for help in the short term.
- Patients' records showed that specialist palliative care nurses had assisted with nursing and treatment interventions in order to support nurses on the ward. This included the management of intravenous lines and support with medication management.
- During the nurse handover on a care of the elderly ward, staff discussed patients' condition and needs in detail. This included changes in condition, pending tests, other speciality involvement and social needs. They said where a patient was receiving end of life care they would ensure all staff on the ward were made aware, not just the nursing staff who were expected to deliver the care in that ward area.
- Ward staff said that the out-of-hours services for end of life care were "excellent." They could contact the out-of-hours Macmillan service or the 24-hour advice line based at the local hospice.

Medical staffing

- Some junior doctors said there was some reluctance at times to institute palliative care following the withdrawal of the Liverpool Care Pathway. They were not familiar with the current pathway and said this was due to it being "so new."
- There were no palliative care consultants employed by the trust. This post was open for recruitment, however, to date no suitable applicant had been found. Senior managers were discussing plans to make the post more attractive to applicants such as a possible link to another hospital. In the absence of this specialist consultant the trust was being supported by the palliative care consultant at the local hospice.

Are end of life care services effective?

Requires Improvement

The trust was in the process of developing its end of life care service, following changes to best practice guidance. As a result, some staff felt less confident about providing effective care for patients at the end of life. With regard to nutrition and hydration, staff did not assess people's needs and delivered care and treatment in line with current standards, and national or internationally recognised evidence-based guidance. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations. There was good provision for out-of-hours support from palliative care specialists, however, not all staff were aware of how to obtain it.

Information on the outcomes for people using the service was limited. The trust was awaiting results from a national audit and had only just started designing a bereavement survey. The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment, such as the provision of syringe drivers to promote rapid discharge for patients who wish to die at home.

Evidence-based care and treatment

- Staff said that the provision of end of life care at the trust was improving, however, they acknowledged that there was "some way to go yet".
- The end of life facilitator said they were now using the NHS England guidelines Principles of care and support for the dying patient in preference to other guidance.
- The trust was not working towards the Gold Standard Framework for end of life care.

End of life care

- Senior staff said that palliative care specialists at the local hospice were helping them to develop the policies and procedures around end of life care provision. This included developing a new bereavement survey.
- The end of life care facilitator was working with three other trusts to develop a linked end of life care plan. They expected a pilot to be ready for trial by autumn 2014.

Pain relief

- Patients received medication to relieve pain and as anticipatory medicine for those who may experience pain in the future.
- There were two types of assessment of pain in use. Staff completed these hourly and, where a score was recorded, which indicated pain, administered analgesia. Staff then recorded the effects of this analgesia and monitored it.
- Nursing staff said they could contact a doctor "at any time" if a patient was in pain. They said the doctors were "generally responsive." Nurses said this support from doctors was "not always so good" at the weekends when there were fewer doctors on duty.
- One patient who was receiving palliative care had shown signs of pain during care interventions. Pain relief had been prescribed and administered to good effect and the patient was comfortable during care delivery. This showed nursing staff recognised when patients were showing signs of distress and acted appropriately to ensure their comfort.

Nutrition and hydration

- Nurses were unclear of the rationale for the frequency of weighing patients at the end of their lives.
- The May 2014 National Care of the Dying audit showed that the trust performed better than average regarding reviews of patients' nutrition and hydration requirements.

Patient outcomes

- The trust had submitted data for the National Care of the Dying audit, which was reported in May 2014. The results highlighted that the trust did not have adequate systems in place for five of the seven organisational key performance indicators, which was similar to other hospitals. Their performance on the ten clinical KPIs ranged from 70% to 100%, which was consistently better than average.
- The trust had taken part in the Cancer Patient Experience Survey 2012/13 and the senior specialists in cancer care were developing an action plan from the results.
- There was no bereavement survey undertaken, however, action to develop this was ongoing with input from the specialist palliative care team at the local hospice. The mortuary manager said they were also involved in the development of this survey in order to measure the effectiveness of the service they provided.

Competent staff

- The use of the Liverpool Care Pathway as a guidance tool for the care of the dying patient had been removed ahead of the July 2014 deadline. In its place the trust used the NHS England Principles of care and support of the dying patient. Staff understanding of this care pathway was in its infancy as it was only introduced two weeks prior to the inspection. Although the trust had plans to deliver training and support to staff, there was no written programme for this and staff were not aware when they would receive the training. This meant staff could be delivering end of life care without the knowledge and skills to do so.
- Nurses said there was good support regarding end of life care. One person said "they [the end of life care facilitator] are fantastic, their knowledge is superb".
- They all cited the support and training from staff at Willow Wood Hospice as being helpful describing it as "excellent," "brilliant," and "a great help".
- Some of the junior doctors said that they felt less confident prescribing medication for patients at the end of their life since the withdrawal of the Liverpool Care Pathway. They said they required more support in this area.

Multidisciplinary working

- Staff said the internal multidisciplinary team, within end of life care, worked "very well." This team consisted of the patient, their family as appropriate, the Macmillan nurse, the ward nurse, the doctors, physiotherapist, occupational therapist and any specialist as required, including social workers, speech and language therapists or specialist nurses. This showed effective multidisciplinary working for patients at the end of their lives.
- If the discharge of a patient was being discussed, the Marie Curie discharge coordinator and a specialist nurse from the local hospice would be present if appropriate.

End of life care

- Staff in A&E said there was no electronic system to alert them that a patient was under the care of the palliative care team. The staff on the medical assessment unit said there was "nothing to flag them up" if a patient known to the palliative care team was admitted. This could mean there could be a delay in, or lack of contact with, the necessary specialists.
- Staff said there were mechanisms in place to share information if a patient who was admitted to Tameside General Hospital was receiving care at the local cancer care centre. There was also an electronic system in development.

Seven-day services

- After 4pm and at weekends staff could obtain advice from the helpline at the local hospice where specialist palliative care nurses were available.
- A hospital palliative care nurse was available at weekends 8am to 4pm.
- The palliative care consultant at the local hospice was available to provide telephone advice if required at weekends.
- Some staff were not aware of the out-of-hours arrangements for contacting specialist palliative care advice and support. One senior staff member said "there is no out-of-hours system that I am aware of" and another said "I can contact the Macmillan nurses until 3.30pm but there is nothing after that." This could mean that a patient may not receive appropriate care and treatment if a staff member did not seek specialist advice out of hours.

Are end of life care services caring?

Good

Staff treated people at the end of their life with kindness, dignity, respect, compassion and empathy while providing care and treatment. Staff provided patients and those close to them the support they needed to cope emotionally with their care and treatment. The chaplaincy service was increasing their links with the end of life care team to ensure they provided adequate emotional support to patients and families. The mortuary provided a respectful and dignified service to the deceased patient and their families.

The trust had taken steps to ensure that patients and those close to them were "partners" in their care and treatment. However, records of these discussions were inconsistent.

Compassionate care

- We observed staff interacting with patients in a kind and caring manner. They were patient and calm in their approach. Staff communication with patients was friendly and polite.
- An agency staff member said the end of life care at the trust was "very good" stating patients at the end of their lives were "happy in this trust."
- Staff protected the dignity and privacy of patients, ensuring bathroom doors were closed and curtains were closed around beds when providing care interventions.
- Staff showed respect for patients who were nearing the end of their lives. Staff sat next to patients and talked with them, while assisting them with food and drink. Staff explained how they would move patients to a side room for increased privacy and dignity, if it was appropriate and met with the patient's wishes.
- We saw 'thank you' cards which reflected staff had provided good care at the end of a patient's life. These included thanking staff for being "caring and considerate in [the patient's] final days" and "thank you all so much for your kindness and being with [the patient] when they passed".
- The mortuary manager spoke with dignity and respect about the care afforded to patients following their death. They discussed how they provided feedback to the wards and individual staff if patients arrived at the mortuary with their appearance wanting in any way.
- The mortuary manager discussed how they had trained staff to understand the need to treat the deceased with care and respect and as if they were "their own relative".
- The way deceased patients were transported to the mortuary had been changed to ensure a more dignified journey. The trolley used for transportation was now made up like an empty bed, with pillow and bedspread, which looked very discreet.
- Staff in A&E said they would not unnecessarily move a patient if they were at the end of their life, even if this resulted in a breach of waiting times. They stated this had been the case three times in the past few months

and each time they had provided the care and support needed on the department. This included provision of a quiet area to give the patient and family privacy and the provision of refreshments.

Patient understanding and involvement

- Staff on the wards and departments all discussed how the patient's family or friends, as appropriate, would be involved in any discussions and decision making regarding a patient's end of life care.
- Staff discussed the need for them to understand the patient's wishes around any specific needs they had, such as their preferred place of death. We saw this was documented in the patient's notes and, where any issues had arisen, such as concern regarding continued support in the community, all those involved in their care were consulted.
- Staff said there had been recent changes to the DNA CPR orders and resuscitation policy, which had resulted in "patients and relatives being more involved and informed" in the decision making. Nurses said doctors were "generally very good" at having these discussions with patients and relatives and felt this had improved recently. Senior managers said that they developed video training to help staff have these difficult conversations with patients and their families or carers; they intended this training to be rolled out across the trust.
- On one ward, staff said doctors held meetings with families and patients, if appropriate, and explained the DNA CPR decision clearly to them. They were also willing to hold further discussions if families needed time to consider the difficult information they were given.
- The wards and departments had a named nurse system and this was displayed on the ward noticeboard so that anyone entering the ward could see who was in charge of the patients' care that day. We were told that, should a patient be poorly and close to the end of their life, all those working on the ward would be informed so that the necessary privacy and dignity would be respected by all.
- The staff on all the wards and departments discussed how the relatives or those closest to the patient at the end of their life would be accommodated to spend as much time as they wished with the patient. Staff said the day room or another similar room would be made available for family members and they would be given open visiting.
- One person raised concerns about their relative's recent experience of end of life care at the hospital, which included allegations regarding the lack of information about palliative care. This person intended to make a complaint to the hospital. The trust said they would investigate.

Emotional support

- The newly appointed lead chaplain said the service had seven chaplains and volunteer ministers from various faiths who provided emotional support to patients and their families.
- When a patient and family wished for a chaplain to attend at the end of life, staff recorded this in the notes. The lead chaplain said the staff involved the chaplains in the end of life care of patients. However, they were now working with the end of life care facilitator to further develop the service within the overall end of life care practices and procedures in the hospital.
- When staff were concerned about the mental health of a patient, they requested the assistance of the specialist mental health team. Staff said the specialist mental health team would be involved, if appropriate, in the discharge planning for patients at the end of their lives.
- Staff said they could access counselling if they required it, from the occupational health department.
- Staff offered each other support regarding potentially emotionally upsetting events.

Are end of life care services responsive?

Good

The trust planned and delivered its end of life service to meet the needs of different people. Although the trust did not have a palliative care consultant in post, there was an adequate system in place to ensure that staff were able to access support from palliative care specialists in a timely way. Some staff recognised that they required further training in the care of people with dementia at the end of their lives.

The trust had improved the way staff took account of people's needs and wishes at the end of their lives, including at referral, admission, discharge and at transitions. However, some patients lacked information to help staff provide personalised care. Some staff recognised

that they required further training in the care of people with dementia at the end of their lives. The trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Staff on the wards said that if they were busy and had a patient who was at the end of their life and required one to one time they could contact other wards to ask for additional staff.
- The trust used agency staff to enable staff to meet the needs of the patients. One agency staff member said they had received an induction onto the ward and had an in-depth handover. They said other staff would inform them if any patient was unwell or approaching the end of their life.

Access and flow

- Staff on the medical assessment unit said they had a "board round" every day which consisted of a discussion, with the doctors, regarding each patient. At this time, any patient requiring end of life care would be identified. The relevant care would be provided or they would be moved to a more suitable environment when a bed became available. This meant patients potentially at the end of their lives were identified at an early stage in their admission.
- The consultant from the local hospice was in contact with the medical assessment unit every day and staff would discuss the care of any patients at the end of their life. Where necessary, the consultant would provide advice and support.
- Data provided by the hospital showed that, in the last three months, 63% of patients thought to be in the last 12 months of their lives had a preferred place of death recorded. This had increased from 29% in the previous three months. This showed a marked improvement in the understanding of staff to obtain and record this information as part of the involvement of the patient or their family.
- Of the 10 of those patients who died in quarter three of 2014/15, three were transferred to their preferred place of death, two patients died in hospital at the family's request, two patients rapidly deteriorated and died before they could have been moved, and the remainder died while awaiting community support. These cases were discussed by the end of life team in an effort to understand and improve the service.
- There was a rapid discharge facilitator, a Marie Curie nurse, who could be contacted any time to support a patient at the end of their life who wanted to leave the hospital quickly. A senior staff member on the medical assessment unit said they had accessed this service and a patient had been discharged within one hour, as was their wish.
- The Macmillan nurses also accessed the rapid discharge team when they needed to facilitate a patient leaving the hospital quickly. They gave examples of when they had discussed a patient's discharge to the hospice at 10.30am and the patient was admitted to the hospice, for symptom control, the same evening. Another patient had been seen by the discharge coordinator at 3pm and returned home, as they wished, a few hours later. This showed a responsive discharge service was in place.
- The end of life care facilitator said there were three syringe drivers which were used for rapid discharge. These were stored in the discharge office, accessible 24 hours per day, and were used to ensure a patient did not have to wait for community access to a machine in order to be discharged. This showed a good understanding of how the needs of patients at the end of their lives could be met to ensure their own wishes were upheld.

Meeting people's individual needs

- Staff discussed how they would assess individual patient needs. Patient records demonstrated these various assessments. This included assessments for physical, emotional and social care needs which meant staff used a holistic approach.
- Where a patient had complex needs and was at the end of their lives, staff took into account the way these needs may affect their care. For one patient with a known diagnosis of dementia, the specialist mental health liaison team for older people had been involved in their care and discharge planning, providing support and advice to the patient and their family.
- Some staff said they had not had any recent training in the care of people with dementia; for several staff members, it had been years. This meant that patients living with dementia at the end of their lives may not have received the care and support they needed in hospital due to staff not having the knowledge and skills.

End of life care

- The mortuary manager said they shared the on-call rota at weekends if there were likely to be multiple requests for viewings following the death of a young person.
- Staff said a translation service was available in the hospital and this could be accessed, for certain languages, if required.
- The chaplain said the variation in faiths of the chaplaincy team meant patients from a Muslim, Hindu, Roman Catholic or Church of England faith could see a chaplain for their faith. This showed the trust understood and could meet the needs of the local community.
- We looked at 11 DNA CPR orders on three wards. These varied in completeness for why the decision was made and who was consulted. Five of the DNA CPR orders showed there had been no discussion with the patient or their family. For three of these five patients the reasons for this were not documented in the patient's records. The lack of discussion with family or the patient is contrary to the trusts own policy which states "Clinicians must always record why a patient was not informed or involved in a DNA CPR decision" and "Clinicians must document any discussions held with family members or the reasons why if discussions have not taken place".
- Two of these three patients had diagnosis recorded which might affect their capacity, for example, "learning difficulties with Downs Syndrome" and "frailty/vascular dementia." The trust's policy stated that, where a patient lacked capacity, any previously expressed wishes should be considered and the risks, burdens and benefits should be "the subject of discussion between the healthcare team and those representing or close to the patient". These decisions were not documented. This meant that staff did not take reasonable steps to include the views of other relevant people.

Learning from complaints and concerns

- Staff said they discussed feedback from complaints or concerns at handover if it was relevant to their area of care. They discussed relevant learning's to avoid complaint recurrence and said the communication around complaints was open and transparent.
- A change had been made regarding the records of a deceased patient, in order to improve the service for bereaved families. The records now accompanied a patient to the mortuary, rather than going to medical records first. This meant there was no delay for families when they visited the bereavement office to register the death. This change was made following the understanding of the effect of delays for the family of the deceased.

Are end of life care services well-led?

Good

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for people. There had been changes to the senior management team in end of life care at the trust over the last six to 12 months. Staff said these changes had resulted in an increased profile for end of life care within the trust, encouragement for staff to be innovative regarding how to deliver that care and staff of all grades being able to voice their ideas, feel listened to and have ownership for them. The governance arrangements ensured that staff were clear about their responsibilities, staff regularly considered quality and performance, and staff identified, understood and managed risks.

The leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The trust engaged with people who used the service, public and staff, seeking and acting on their feedback. This meant the trust took adequate steps to learn continually and improve, to support safe innovation, and to ensure the future sustainability and quality of end of life care, such as working with other local trusts to develop an advanced care plan.

Vision and strategy for this service

- There was a non-executive director with a lead role in end of life care and the end of life care facilitator said they worked with them to discuss the developments within the trust.
- The end of life care facilitator discussed how they wanted to ensure patients in the hospital received good end of life care by establishing a recognised pathway of care, introducing good care planning and increasing training for all staff.

End of life care

Governance, risk management and quality measurement

- Staff said there were various audits carried out with regard to end of life care. These included monthly audits of the number of patients who had a completed advanced care plan. Staff said this had increased from 12% in quarter three to 24% in quarter four.
- The consultant from the local hospice carried out an assessment of the specialist palliative care multidisciplinary team in October 2013. They scored 84% out of 100%, with no significant risks being identified.
- The Macmillan nurses carried out a survey of patient satisfaction with their service in July 2013. They received 15 responses which were all 100% positive in respect of the dignity the nurse showed, the way the nurses listened to patients and families and the length of time it took for the nurses to contact patients and families. The survey resulted in changes to the service, such as more robust systems for obtaining consent for referrals.

Leadership of service

- The end of life care facilitator had been in post since September 2013. This was a temporary post for 12 months. Staff said they had been "a great help in raising the profile of end of life care in the hospital." Staff of all grades said how they found the facilitator to be "knowledgeable," "passionate about end of life care," and "full of good ideas for developing the service."
- The cancer services manager had a strategic role and was evaluating cancer services in the trust.
- The end of life care facilitator had introduced the role of link nurses and there was one or two on each ward and department. The link nurses had received additional training and support to become the lead in end of life care. Other staff on the wards spoke of this being helpful in supporting them to deliver good end of life care.

Culture within the service

- The staff were positive about the changes which had already occurred and the planned developments in end of life care within the trust.
- They described their roles as being "busy and industrious" saying they were "moving forward" generally.
- Senior staff said they were encouraged to present ideas with regard to changes in end of life care and these ideas were "listened to." They all felt that providing good quality care for the patients was now at the centre of what they were all doing and the focus for management.
- Those staff who were developing ideas for change within the service said they now felt an "active part of the change process." We saw they were enthusiastic about their own roles and how they could support others through the change.

Public and staff engagement

- Staff said more work was being carried out to increase the public engagement with regard to end of life care. Due to the sensitive nature of this the senior staff were working with experienced staff at the local hospice to develop ideas for further engagement.
- The end of life care facilitator had an intermittent table top display as part of the 'Dying Matters' campaign. This was carried out respectfully and in a way which encouraged public involvement.
- Staff said the awareness of end of life care in the hospital had grown over the past few months and they were interested in becoming involved in projects, such as the link nurses project.

Innovation, improvement and sustainability

- The majority of the positive comments we received about the improvement made in end of life care, centred around the end of life care facilitator.
- Staff were keen to roll out initiatives which would ensure other staff members had ownership for the various developments which were taking place. This included supporting the lead chaplain to increase the role of chaplaincy within end of life care and working with the mortuary manager to improve the environment and services offered by the mortuary and the bereavement office. Ward staff attended training events to improve communication with a dying patient and the trust cascaded latest guidance about end of life care through the link nurse project. Much of this work was in its first few months of development.

Outpatients

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

Information about the service

The outpatient service at Tameside General Hospital expects to have 85,250 patients attending for their first appointment in the year 2014/15 and 154,348 patients attending for follow-up appointments, which reflects steadily rising figures over the past three years. Most clinics were located in two areas of the hospital. The main area was at the Hartshead south entrance and was modern and bright. The facilities provided included a café, shop, large waiting areas, an information service, reception areas and electronic check in kiosks. There was a separate children's outpatient service situated in this area.

Around 500 children attended the children's outpatient service each week. The service consisted of 10 consulting rooms, a room to make casts, a weighing room and an audiology room.

During the inspection, we visited eight clinics and spoke to 16 patients and their relatives, 15 staff members of various grades, nine administration staff, and senior staff responsible for service improvement in the outpatients departments. We observed interactions between patients and staff and reviewed records relating to the management of the service.

Summary of findings

The trust was implementing a new electronic patient health record system called Lorenzo. This is a national system. This implementation has given the trust some problems and challenges. The migration from the old system to the new one was of particular issue and concern.

The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment. However, staff in some areas felt that low staffing numbers had a negative impact on patient experience. The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. However, delays in the triaging of referrals meant that the trust did not take adequate steps to reduce delays for patients who urgently needed investigations. The trust did not have adequate systems in place to monitor the satisfaction (outcomes) for people.

Although the children's outpatient service was responsive to the needs of children, parents and carers, the trust did not have an adequate system in place to deliver its outpatient services to meet the needs of adults. Adults sometimes experienced long waits and did not receive accurate information about their appointments. The trust did not take adequate steps to ensure that people accessed its services in a timely way. The trust was aware of the concerns around access and

Outpatients

flow and had put short-term measures in place to improve the service. They had recently begun a project to audit the service and make improvements in clinic productivity and patient experience.

Staff were working towards the project objectives. As these arrangements were new, the trust was not able to ensure that staff were clear about their responsibilities, that staff regularly considered quality and performance, and that staff identified, understood and managed risks.

Are outpatients services safe?

Requires improvement

The trust assessed and monitored safety in real-time and reacted to changes in risk levels in the service or for individuals. However, delays in the triaging of referrals meant that the trust did not take adequate steps to reduce delays for patients who urgently needed investigations. Staff anticipated potential risks to the service and made plans in advance to mitigate these risks. However, the trust did not ensure all staff were aware of these plans, such as for the moving and handling of bulky patient records. There were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.

The outpatient areas were clean and tidy with patients commenting favourably on the general cleanliness of the individual outpatient areas. There were good facilities for patients such cafés, a shop, an information centre and voluntary services to offer support. Staff kept their mandatory training up to date. There were sufficient staff on most clinics to cope with busy periods, however, staff in some areas felt that low staffing numbers had a negative impact on patient experience.

Incidents

- There were no Never Events (serious harm that was largely preventable) in the outpatients departments in the preceding 12 months.
- Staff knew what constituted an incident and how to report an incident.

Cleanliness, infection control and hygiene

- The toilets, waiting areas, seating and examination rooms in the outpatient departments were clean. One patient said “the place is spotless” and two others said it was always clean.
- The clinic rooms had cleaning schedules although they had not all been fully completed which meant that the trust could not provide assurance that staff cleaned areas in line with the current guidance for infection control.
- There were hand-washing facilities located in areas such as toilets and examination rooms with hand gel being prominent and signposted in the entrances to the clinics.

- Staff washed their hands and used personal protective clothing when required.
- In the children's outpatients department the hand wash areas and gel dispensers had been made more appealing to young people with the use of brightly coloured animal stickers.
- In the phlebotomy department there were linen curtains used around the cubicles. One curtain had a stain. Staff were not sure what the rota for changing the curtains was.

Environment and equipment

- Patients said they thought the environment was good "compared to how it used to be and some others."
- Staff said they had the equipment they required to carry out their work, such as diagnostic equipment and disposable examination equipment. The equipment was clean and well-maintained.
- There were records of regular checks of the resuscitation trolleys and staff were aware of the location of those trolleys not situated in the main clinic area.
- Staff said they had the space they required and the waiting areas generally did not become too overcrowded. There was a range of seating in the clinics, including raised chairs.
- The children's outpatient department was distinct from the adult area in that it had a brightly coloured entrance with a locked door. Access was via a buzzer system monitored by the receptionist.
- The whole children's outpatient waiting area could be viewed by the receptionist ensuring they would be aware if there were any issues which required attention.
- Staff said that the lift in the administration building, where records were held and letters were typed following clinics, had been out of order for three days the week prior to our inspection. They said this was not the first time it had occurred. During this time records could not be moved from the first floor in bulk quantity which caused delays in returning them to medical records.
- Staff said that repairs were not always carried out in a timely fashion. In one office, lights had been out of order for three days with no additional lighting provided. Staff completed the typing of letters in this area and it was dark which staff said was causing some difficulty.

Records

- Records were securely stored in the clinic areas in locked trolleys.
- There was written guidance for staff regarding confidentiality of records.
- One staff member left her log-in card in the computer when it was unattended. This could lead to a breach of data protection.
- The trolleys containing the patient records in the outpatients departments were overstocked in some areas. Staff said "bulky patient notes" could be very heavy and one staff member said one set had weighed 14kg. Staff had raised this as a moving and handling concern; however, they were unaware of any action taken by the trust to manage this risk.
- Patient records were stored on shelving and the floor in the administration offices and typing pool. Moving the records involved lifting heavy boxes and we observed a staff member doing this. This storage caused concerns regarding safe moving and handling and trip hazards for staff.
- Administration staff said there were not enough trolleys to move the records out of this building back to medical records and this was contributing to the large number of records stored in the building. This added to the delay in records being returned to the medical records department.
- Staff said the availability of patient records for clinics was "generally okay" and that it had improved. In one clinic, staff said three patient records had been missing for that morning's clinic, however, staff also said that they informed medical records, who generally found the missing notes "very quickly" and provided them to the doctor before the end of clinic.
- There was an electronic record tracking device which meant records were scanned into the system and a member of staff, using the hand-held device, could locate specific records throughout the hospital. This had contributed to reducing the number of missing patient records in outpatient clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the need to obtain consent for some procedures and explained when written consent would be required as oppose to verbal consent.
- There was awareness among the staff that any patients with dementia or a learning disability may require additional support. They described how they would assist them to have a reduced waiting time and accommodate any carer who was accompanying them.

Outpatients

- One patient said their carer could "go everywhere with me" which they explained "put them at ease."
- We were told, by staff in the health information centre, that there was a specialist learning disability nurse who would support staff to assist patients with a learning disability. This included communication issues, consent or accessibility to services. Staff in the outpatients departments had not used this service.

Safeguarding

- Staff said they had received training in the safeguarding of vulnerable adults and children and this was updated annually.
- The staff members said they did know the whistleblowing procedure and would raise concerns with their line manager, or if they were implicated, to the next most senior manager.

Assessing and responding to patient risk

- Staff said doctors were available if a patient became ill. If necessary, doctors referred patients to be admitted under a relevant consultant, for assessments and treatment in hospital.

Mandatory training

- Staff said they received mandatory training and kept it up to date.
- There was a system in place for reminding them when their training was due.
- Data provided by the hospital showed that, in February 2014, mandatory training for general outpatients was between 90% and 100%. The percentage of staff who had personal development reviews was slightly lower than 90%. These figures had improved over the past four to five months and showed a commitment to ensure staff were adequately trained.

Nursing staffing

- The views of the nursing staff, regarding the staffing numbers, were varied dependent on the individual specialism.
- Nurses on the breast clinic said there should be five staff to cover the clinic and, on the day we visited, there were three. They said this leads to stress for the staff who work overtime to offer cover, and can lead to delays for the patients in the clinics.
- The staff survey showed staff were more likely to be working extra hours compared to other trusts.
- Nurses said there was an over-reliance on agency staff; they felt recruitment should be increased to ensure permanent staff were available.
- Nurses said the new e-rostering system meant there was a lack of consistency of the clinics they worked and this meant they were not always familiar with the preparation for examinations or how the doctors liked their clinics to run. They felt this was not an efficient way to manage the staffing of the clinics. This had been raised with the managers in some clinics, however, staff were unaware of any actions being taken.
- Staff said that, during busy times in outpatients, they worked "a lot of extra shifts". Otherwise, agency staff were used.
- Staff in clinics with a more unpredictable workload, such as fracture clinic, said there were times when there were not enough staff in the department. This meant patients were kept waiting longer.

Medical staffing

- The medical staff said they felt the clinics ran efficiently.
- One doctor said there were times when there were not enough staff to make casts and this could lead to delays which in turn led to a crowded waiting area

Non-clinical staffing

- The secretaries said there was a decrease in staffing levels, as individual secretaries were replaced by staff in a typing pool. There was also an increased workload with the addition of letters resulting from clinics held in other hospitals by a consultant based at Tameside. This resulted in delays in answering the phones and sending out letters.

Are outpatients services effective?

Not sufficient evidence to rate

The trust did not have adequate systems in place to monitor the outcomes for people. Therefore, they could not review the outcomes for people using the service against other services. The trust had recently begun a project to audit the service and make improvements in clinic productivity and patient experience. Staff were working towards the project objectives.

The trust made sure that staff, equipment and facilities enabled the effective delivery of care and treatment. Staff

felt well-supported to carry out their roles. The trust supported and enabled multidisciplinary working within and between services across the organisation, as well as with external organisations.

Evidence-based care and treatment

- The trust had just begun service improvements which included the development of clear operational policies, agreed standards of working and training packages for staff. The overall goal was to ensure there were clear, evidence-based procedures in place in order to improve the outpatient service. At the time of the inspection, however, this was not yet fully implemented.

Pain relief

- Clinics operated differently. This made it difficult for the trust to monitor patient outcomes.
- Of the 16 patients we spoke with, 14 were satisfied with the overall experience of visiting the outpatient department.
- They said the service was “good,” “we don’t have any concerns” and “I feel really comfortable here.” They spoke of the staff being “great,” “friendly and polite” and “taking their job seriously.”
- The reason one of the two patients was not satisfied was they had tried to cancel an appointment and no one had answered the telephone.
- The trust had begun an audit of the current outpatient service in order to improve specific areas. The audit included reviewing the rate of non-attendance, the “choose and book” utilisation, clinic productivity, development of a sustainable, 18-week performance and improvement of the patient experience. At the time of the inspection, the project was in its infancy, as the trust had only recently produced the brief.

Competent staff

- Staff said they had received supervision and appraisals from their line managers.
- They said they felt well-supported to carry out their roles and they all helped each other.

Multidisciplinary working

- Staff were not able to provide evidence of good multidisciplinary working which had positive impacts on patient outcomes.
- Some clinics had specialist nurses, such as the head and neck cancer nurse, working alongside consultants. This meant the patients had input from specialist nurses, if required, from their first appointment.
- Staff said that specialist consultants, such as one dedicated to speech defects, worked in the clinics on a session basis to ensure patients had access to the specialists they required to meet their individual needs.
- Some clinics were linked with specialists from other hospitals to ensure patients received a good service. Staff described one collaborative service by saying it “works well”.
- There was a play specialist who helped to calm children needing tests. They also entertained children in the waiting areas. Staff liaised with the child psychologist if needed

Seven-day services

- There were additional non-routine clinics scheduled for Saturdays and evenings to reduce the waiting lists. Staff said the evening and weekend clinics were popular with patients.
- One of the aims of the outpatient project was to “improve the productivity – i.e. the number of patients seen in outpatients clinics”.
- There were Saturday and evening clinics held in the children’s outpatient department. There were plans to increase the number of these, in response to feedback from parents.

Are outpatients services caring?

Good

The trust involved people who used the service and those close to them as "partners' in their care and treatment. Staff treated people with kindness, dignity, respect, compassion and empathy while providing care and treatment. However, staff in the phlebotomy unit did not take adequate action to support people who needed additional help.

Staff supported people to make informed decisions, although the electronic systems in place did not ensure that people received adequate and accurate information about their appointments. Staff provided patients and those close to them the support they needed to cope emotionally with their care and treatment. Staff in the children’s outpatient service were particularly sensitive to the potential for anxiety in children and took measures, such as play therapy, to alleviate this.

Outpatients

Compassionate care

- During the interactions we observed in the outpatient clinics, staff were polite, kind and respectful to patients.
- They called patients through to the clinic from the waiting room using their full name, introducing themselves and guiding them politely to the correct place.
- Staff in the phlebotomy clinic did not always offer physical help to those who found it difficult to move when their number was called, for example, a patient in a wheelchair.
- In most clinics, staff protected the dignity of patients when consultations or examinations were taking place by closing curtains and doors. However, in the phlebotomy unit, the curtains were not always closed during procedures. This meant the dignity of those patients was not protected.
- Patients said the staff were “kind” and “very good.”
- Staff in the children’s outpatient department were polite and friendly. Parents in the children’s outpatients department said their children were “happy playing and not frightened.”

Patient understanding and involvement

- One child had needed to be at the children’s outpatient department most of the day due to tests being undertaken. The parent said they had been given good information and it was not difficult being there all day as their child was happy.

Emotional support

- The Macmillan nurses said that they attended outpatients to offer emotional support for those patients who may receive news about cancer diagnoses. If tests had been carried out and results of concern were to be discussed with a patient, the Macmillan nurse would be informed in advance, where possible, so they could attend the clinic.
- The Macmillan nurses carried out their own clinics as well as supported those led by a consultant. This meant they could give emotional support, guidance and advice when required.
- At the time of our visit, outpatients clinic was not busy; we did not have an opportunity to observe staff providing emotional support.
- Patients said the staff were “helpful”.
- Staff in the children’s outpatient department were focused on ensuring the child and the parent were relaxed.
- There was a play specialist employed who assisted children in the waiting area, while answering the questions of parents. They helped parents understand the processes of the clinic. They also helped to calm any patients who required interventions, such as blood tests, using play to distract and relax them.

Are outpatients services responsive?

Inadequate

Although the children’s outpatient service was responsive to the needs of children, parents and carers, the trust did not have an adequate system in place to deliver its outpatient services to meet the needs of adults. Adults sometimes experienced long waits and did not receive accurate information about their appointments. The trust did not take adequate steps to ensure that people accessed its services in a timely way. However, the trust was aware of the concerns around access and flow and had put short-term measures in place to improve the service.

The trust took account of people's needs and wishes throughout their care and treatment, including at referral, admission, discharge and at transitions. The trust routinely listened to and learned from people's concerns and complaints, to improve the quality of care.

Service planning and delivery to meet the needs of local people

- There was an understanding among staff that clinic end times could be variable, to meet the demands of the service, and the staff accommodated this.
- Staff said that the non-attendance rate at some children’s clinics was high as 20% and the trust was working to improve this, by sending out text reminders and providing Saturday clinics.
- Staff tried to ensure that appointments for young people did not take place at exam time.
- The environment in the children’s outpatient area had been designed as a result of consultation with children from a local primary school so that it appealed to children and young people. The walls had brightly coloured panels and drawings, which followed the theme of animals and we were told were changed so those frequent visitors saw a varied display. The animal

theme was carried through to the consultation and examination rooms with pictures, toys, suitable child's furniture and adapted equipment such as beds which looked like large animals.
- In the children's outpatient area, there were a large number of toys and games to suit various ages and abilities, including a games console, large board games, figures, cars and books. There was a small table with drawing, colouring and other craft activities available.

Access and flow

- Patients said they had not had to wait long to get an appointment at outpatients. One person said they had waited "just two weeks and suppose that's fine." Another said "not long at all, I can't complain".
- One patient praised medical staff in the cardiology clinic because they had called them at a weekend and arranged a weekend appointment, showing that patients' individual circumstances were recognised.
- There was a text reminder service, however, not all patients had received this. It was designed to reduce the rate of non-attendance and was to be reviewed as part of the outpatient project.
- There were electronic check-in systems at the two main entrances to the hospital. The patient logged their arrival and were informed where to go for their appointment. We saw there were two of these in one area and three in another and there was no waiting time to use them. Receptionists were available in both areas for any patient who found this system difficult to use.
- The non-attendance rate was 11% at the time of the inspection and staff said the target had been set at 7.5%. One of the aims of the outpatient project would be to understand why this rate occurred and to reduce it.
- Patients attending outpatients for an appointment said they had not been waiting long to see the nurse or doctor. Those who had visited several times said they "usually don't wait long." The average wait was 15 to 20 minutes which the patients said was acceptable.

Delays

- The trust reported a significant increase in the number of patients waiting over 18 weeks from referral to treatment which grew from 500 in September 2013 to 4000 in February 2014, as a result of problems with the implementation of their new electronic records system.
- Senior staff said the waiting time for the first appointment was five to six weeks. The aim was to enter referrals onto the system the day they were received or at most one day later.
- On 8 May 2014, letters from 30 April 14 onwards had not been entered on the computer system or actioned (for example, an appointment made). This meant there was a delay of nine days before referral letters were reviewed, even if the referral was urgent.
- Staff said extra temporary staff had been brought in to help clear this "back log", however, they were not aware of a longer-term solution.
- A triage process had been introduced which meant some consultants read their own referrals and prioritised these as necessary. This process occurred only once the administrators had entered the referral onto the system, so the delay remained the same.
- The secretaries were particularly concerned regarding the delays in the system which meant urgent referrals for tests, such as angiograms, were taking two weeks when the target was two days. This meant patients could be waiting for urgent tests and deterioration in their condition could occur in that time.
- One patient said there had been a 12-month delay in their treatment which should have taken place within three months and they attributed part of this to the delay in information sharing following their first outpatient consultation. Staff said these delays had been brought to the attention of the managers, however, they were not aware of action that had been taken to reduce the delays.
- As part of the outpatients' project, a patient survey had highlighted an issue with the appointment letters. This was mainly due to the electronic patient record system and had resulted in patients receiving multiple letters for the same clinic, including cancellations. This had led to patients not attending due to the confusion of which was the correct appointment. This was being managed and staff said it was happening less often, but did still occur.
- One patient said their general practitioner had not received a letter following their outpatient appointment two months previously. The medical secretaries said they were currently typing letters from the clinics held four weeks ago. Letters from the dermatology clinic were being typed four weeks following the consultation when the target was five days for a routine appointment

and two days for an urgent appointment. This meant there was a delay in other professionals, such as GPs, receiving the information they required to appropriately manage patients.

Meeting people's individual needs

- There were wide doorways and wheelchairs which were available in the entrance for use by patients.
- There was a volunteer service which provided scooter access around the hospital for those patients unable to walk the distance.
- Staff were aware of the need to prepare in advance for meeting patients' complex needs, such as communication difficulties. Staff discussed how patients with a learning disability or living with dementia could move quickly through the department if they had difficulties waiting.
- There was an information service which provided patients with written information regarding their diagnosis, treatment, benefits or any other advice they required. In April, they had assisted 168 patients, the majority being from outpatients. This meant patients could obtain more information when they had completed their appointment, if they wished.
- There was a translation service for the most commonly used languages. Some signage presented information in other languages. Leaflets were available in a variety of languages, including Polish and Urdu to meet the needs of the local community.
- There was a translation service available. The manager of the patient information service said they were asked to provide translators for a number of languages. One of their volunteers spoke Bengali and worked as a translator.
- Patients said they had not been offered a chaperone. Staff were aware of the need to offer a chaperone to patients, however, this was not being done routinely in the clinics we visited.
- The trust did not send patients all required information prior to their appointment. One patient said "I was given a leaflet that explained everything" while another said "I didn't get any information that I needed". This meant not all patients were clear about what to expect at their appointment.
- Some patients said the appointment letter was not clearly written. This resulted in some patients not attending their appointment. The trust planned to "review patient letters for accuracy and ease of understanding." The outpatient managers recognised that the current letters could lead to confusion.
- In the clinics the waiting times were not displayed. This meant the trust did not take adequate steps to ensure patients were aware of how long their waiting time would be. Some patients said staff would visit the waiting room and make an announcement if there were delays. However, we did not observe this practice during our inspection visit.

Learning from complaints and concerns

- Senior nursing staff said they were informed of concerns and complaints which had been raised if they concerned the clinic in which they worked. They said these were discussed in the monthly meetings and the online information system meant they could look at outcomes of individual issues.
- The manager of the children's outpatients department said that, in the six years since the area had opened, there had been no complaints. The manager believed this was because children and parents were happy to visit.
- The trust's review of the Patient Advice and Liaison Service (PALS) and complaints between April 2013 and March 2014 stated the Elective Services division had received 958 complaints: 400 related to appointment delays or cancellation, 173 related to aspects of clinical care, and 171 related to communication or patient information.
- The trust reported that PALS interventions included: re-arranging appointments to meet patient requests and providing contact details.

Are outpatients services well-led?

Requires improvement

The trust had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for outpatients. Although the trust had begun to establish governance arrangements, these were not yet fully in place in outpatients at the time of our inspection. This meant

that the trust was not able to ensure that staff were clear about their responsibilities, that staff regularly considered quality and performance, and that staff identified, understood and managed risks.

For most staff, the leadership and culture within the organisation reflected its vision and values, encouraged openness and transparency and promoted the delivery of high-quality care across teams and pathways. The trust engaged with people who used the service and the public, seeking and acting on their feedback to improve outpatient services. However, some staff felt that the trust did not take adequate steps to seek and act on feedback from administrative staff.

The trust took adequate steps to learn continually and improve, to support safe innovation, and to ensure the future sustainability and quality of care. However, some staff were unaware of these service improvement plans.

Vision and strategy for this service

- The manager of project to improve outpatients said the vision was for the service to be more efficient and to provide a good patient experience.
- There was recognition that clinics needed to follow different processes, however, there was a joint commitment to involve all clinics in improvement work.

Governance, risk management and quality measurement

The outpatients improvement project had begun only three weeks prior to the inspection. The results of the initial audits and surveys, which would be used to produce the new processes and procedures, had not been completed.

The project manager was gathering quality measuring data, however, the outpatient departments lacked robust systems in place to do this. There was no specific measuring tool in place regarding the numerous delays identified by staff.

There was a weekly meeting of the waiting list steering group and they looked at the pressures around specific specialities and decided actions to reduce any waiting times thought to be excessive.

Leadership of service

- Staff in the individual clinics discussed the leadership within that specific clinic, rather than overall leadership of the outpatient departments. It was in the scope of the outpatient project to establish overall leadership for this service within the trust.
- Most staff spoke highly of the trust management board, saying they were visible in their departments at times.
- Clinic staff spoke positively of the changes within the trust and thought “things are improving”.
- The administration staff were less positive regarding the changes and could see only short-term solutions to what they said was a growing problem due to increased workload. They discussed how staff had “gone off sick” or were leaving due to the stress of the workload and concerns around delays for patients.
- Staff spoke highly of the leadership in the children’s outpatient department and said they felt included and involved in the development of the service.

Culture within the service

- All the staff had the patient at the centre of their discussions and clearly wanted to improve the patient experience in outpatients.
- Some staff spoke positively of openness and being able to discuss issues with their managers. However, some clinical staff whose workload had increased and administration staff said they “did not feel [they] were being listened to”. This meant there was a mixed culture with regard to transparency and not all staff were satisfied that their views were regarded as valid.

Public and staff engagement

- There was an eagerness to engage with the public to obtain their views and understand their experience in order to ensure the changes they were proposing met their needs and expectations. This included receptionists, medical staff and volunteers as well as the senior staff leading the project. This showed in the way staff asked patients for informal feedback when talking to them and were open, friendly and visible.
- The outpatient’s project included ideas for stakeholder engagement in encouraging general practitioners and commissioning groups to increase their use of the NHS Choose and Book system, a national electronic appointment system which gives patients a choice of place, date and time for their first outpatient appointment.

Outpatients

- Each week, a volunteer took an electronic tablet around the waiting areas and asked patients for instant feedback on a variety of areas. The main aim of the survey was to understand the attendance rates and possible reasons for non-attendance. The questions included the reasons for missing appointments and the answers included confusing letters, incorrect information or lack of transport. This showed that patient feedback was being sought regularly and this was being used, as part of the outpatient's project, to inform the changes.
- Not all staff were aware of the outcomes or actions taken as a result of concerns and issues raised, for example, the moving and handling issues due to overly heavy patient notes. One senior administrator said these records were the first to be entered onto the electronic patient record system in order to dispense with the paper records, however, other staff were not aware of this. This meant the system for feeding information back was not reaching all grades of staff.

Innovation, improvement and sustainability

- Some of the issues around delays in letters had a short-term measure for improvement in place, such as the use of agency staff to clear the back log. The long-term measures were unclear and staff working in these departments did not know what the plans were.
- At the time of the inspection, the provision of outpatient clinics was under review by the trust and commissioners to ensure sustainability of the services.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had an outside garden area for patients which was dementia-friendly.
- The trust welcomed visits by patient groups, such as Healthwatch or Tameside Hospital Action Group, to see for themselves how the hospital was performing.
- Patients were assessed regarding their rehabilitation needs and the physiotherapy team were available seven days a week to contribute to meeting the goals for each patient's recovery. The physiotherapy team was led by a consultant in physiotherapy so that a senior person was available regarding complex issues.
- One of the hospital's community midwives had recently won the British Journal of Midwifery's Community Midwife of the Year Award. This midwife had been recognised for recently supporting four women with cancer during their pregnancies and reportedly, "Continually goes that extra mile to support women and their families", said the head of midwifery.
- In 2012, the maternity unit launched a fundraising campaign called the Bright Start appeal. This highly successful campaign had funded the development of the birthing pool room and would fund the future development of the midwifery-led birth room.
- The maternity service actively participated in national research and audit projects. This included: "The Healthy Eating and Lifestyle in Pregnancy Study" which was being undertaken with Cardiff University and Slimming World; "The Building Blocks: A trial of Home Visits for first time mothers" in partnership with University Hospital South Manchester and "The Bumpes Trial" which was being undertaken by the University College London.
- The facilities for bereaved parents included a private room, garden and en suite bathroom. The room contained a television, lounge, kitchen and hot beverage facilities. A midwife, usually bereavement trained, was allocated to the family whilst in hospital. After being discharged from hospital, the nurse visited the family at home or contacted them by telephone. The trust held an annual forget-me-not remembrance service.
- The maternity service had developed a teenage pregnancy reduction initiative in response to local need which had a positive impact in reducing the number of teenagers who were expecting their second child. The trust appointed a specialist teenage pregnancy midwife, created a more teen friendly environment, improved the continuity of care from staff.
- The trust worked creatively with commissioners and other trusts to plan new ways of meeting the needs of children and young people. Together, they developed integrated pathways of care, particularly for children and young people with multiple or complex needs.
- The trust had a dedicated children's safeguarding team which evidenced proactive outreach programmes and service adaptations aimed at meeting the needs of people in vulnerable circumstances.
- The trust developed an observation and assessment unit and community nursing team for children and young people, which significantly reduced hospital admissions and accident and emergency department attendance.
- The trust raised the profile of end of life care by appointing an end of life care facilitator who worked with other staff and external agencies to implement best practice in the mortuary and chaplaincy service, improve care on the wards and facilitate rapid discharge.
- The trust had adapted the equipment used for transporting deceased patients to resemble an empty bed. This was discreet and made for a dignified journey through the hospital to the mortuary.
- The trust had three syringe drivers available for the sole purpose of facilitating a rapid discharge for any patient who required this equipment, which was normally supplied by community services.
- The trust's paediatric outpatient department provided a stimulating and interesting environment in the waiting, consultation and treatment areas. This environment had been designed as a result of consultation with a local primary school so that it appealed to children and young people. This included small details, such as a glass cabinet in the reception desk where a toy replica of a hospital was placed to reduce the boredom of children when they were waiting at the desk.

Outstanding practice and areas for improvement

- The trust had an electronic system for logging and identifying patient records, which resulted in improved access to records for outpatient clinics.

Areas for improvement

Action the hospital MUST take to improve

- Take action to ensure that within critical care they have safely stored adequate supplies of medication and that staff regularly check this.
- Take action to ensure that staff, particularly in maternity safely administer and dispose of medications, that staff accurately record this, and that staff regularly check these records.
- Take action to ensure that patient records, such as nursing assessments, procedure books, patient group directives or discharge letters, are accurate and fit for purpose.
- Take action to ensure that staff promptly assess all patients and ensure their welfare and safety, particularly in A&E.
- Take action to ensure staff accurately and regularly check equipment such as resuscitation trolleys across all areas of the Trusts building on the good practice in many areas.
- Take action to ensure that the practice of learning from complaints is embedded across the trust, building on the good practice already in place in some areas as they learn from complaints and concerns.
- Take action to ensure that staff adequately assess and respond to changes in patient condition or risk.
- Take action to ensure that the environment for interventional procedures in coronary care are safe and suitable for treatment.

Action the hospital SHOULD take to improve

- Ensure that all staff (particularly in medical care services and A&E) receive suitable structured supervision building on the work already in place.
- Ensure that all staff, patients and visitors know how to respond to any allegation of abuse.
- Ensure that staff provide external identification for patients, such as a wristband, when patients arrive in the A&E department.
- Ensure that the trust improve the routine monitoring of the care and treatment of patients waiting in the A&E department.
- Ensure that staff (particularly in medical care services) have adequate plans in place to care for people with mental health conditions, including dementia, or challenging behaviour.
- Ensure staff are aware of all appropriate equipment in critical care and how to ensure this is available and promptly repaired if broken.
- Ensure that their Intensive Care National Audit & Research Centre data is kept up to date and used proactively to help monitor the safety, effectiveness and responsiveness of the service.
- Ensure there are robust systems in place to obtain the views of patients and carers regarding care at the end of life and bereavement support.
- Consider how they support staff to quickly identify clean versus dirty equipment; particularly in maternity, children's services and medical care services.
- Consider how they work together with the local community to facilitate safe and prompt discharges.
- Consider how staff in the MHDU/CCU adequately monitor the weight of patients who cannot easily stand.
- Consider the impact of having nurses with combined anaesthetic and recovery responsibilities .
- Consider how their plans for re-developing the critical care service meets the needs of staff and patients.