Central Manchester University Hospitals NHS Foundation Trust

# Altrincham General Hospital

**Quality Report**

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Good |
| Minor injuries unit | Good |
| Outpatients and diagnostic imaging | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Altrincham hospital is part of Central Manchester University Hospitals NHS Foundation Trust and provides hospital services including a minor injuries facility, renal dialysis unit and outpatient services to both adults and children.

Altrincham Hospital is situated in the borough of Altrincham and serves a population of approximately 226,600 people residing in the surrounding area of Trafford, Altrincham and Greater Manchester. The hospital has no overnight stay beds.

We carried out this inspection as part of our scheduled program of announced inspections.

We visited the hospital on 4 and 5 November 2015. During this inspection, the team inspected the following core services:

- The Minor injuries unit
- Outpatients and diagnostic services

Overall, we rated Altrincham Hospital as 'good'.

Our key findings were as follows:

**Leadership and management**

- The hospital was led and managed by a cohesive and visible senior team. The team were very well known to staff and were regular and frequent visitors to the wards and departments. The head of nursing was well regarded by all departments who felt supported and valued by her. Staff were engaged and were committed to the Altrincham hospital providing a high quality service for patients and their friends and families.
- There was a positive culture throughout the hospital. Staff were open and honest and were very proud of the work they did and proud of the services they provided. Although there was additional work to be done to support staff in feeling part of the Central Manchester Foundation Trust as a whole.

**Access and Flow**

- The number of patients leaving urgent care services without being seen across the trust was consistently higher than England average from July 2014 to April 2015. Unfortunately the trust were unable to provide these figures for the Altrincham site specifically.
- The total time patients spent in urgent care services across the trust was consistently lower than the England average from November 2014 to May 2015.
- All patients we spoke with told us they were seen quickly and expressed no concerns about waiting times.
- A transfer policy was in place and this offered guidance on which escorts were required to accompany patients to other hospitals.
- There was a divisional escalation policy in place. This policy guided staff on steps to take if patients were in the unit for longer than expected or were waiting excessive times for an inpatient bed. The policy included clear steps for staff to take and we observed the shift coordinators following this process correctly.
- A winter pressures plan was in place for the Trafford Division and staff within the MIU were aware of this plan.
- We reviewed four records and all four patients were seen within their allotted triage time category.
- Urgent care services across the trust scored about the same as other trusts in England for all three standards relating to access to timely care in the 2014 A&E survey.
- Patients use a 'choose and book' system which allows patients choice when booking OPD appointments.
- Referral to treatment ( percentage within 18 weeks) for non-admitted from November 2014 to July 2014 the trusts performance was lower than the England average and the standard

# Summary of findings

- The failure to attend rate for new patient appointments at Altrincham was 6.9%. This was better than the England average of 8.8%
- The percentage of people waiting over six weeks for a diagnostic test at Trafford and Altrincham was 0.8%. This was better than the England average.
- The phlebotomy clinic at Altrincham was very busy. There was a treatment area with space for four staff. If there was full staffing patients were not waiting long but if not fully staffed patients were waiting up to two hours for a blood test. We spoke to staff and patients who confirmed this.
- The service ran from 8.00am-3.30 pm, though the service became busy early. This was because some patients required fasting blood tests and others were on their way to work. Managers were aware of the problems and another two staff members had been employed to rotate between the Altrincham site and the Trafford site. They were also considering evening clinics and Saturday clinics.
- The transport to the laboratory for blood samples left Altrincham at 4pm, if the service was running late; samples had to be sent by taxi.
- On the renal dialysis unit patients attended on alternate days Monday –Saturday. The first cohort of patients attended early in the morning with the next cohort of patients arriving at 11am. The dialysis treatment lasted about four hours. This meant that 40 patients were seen every day. Space could be found if patients had missed their appointments as there were spare dialysis machines.

**Cleanliness and Infection control**

- Patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust policy on infection control and adhered to the 'bare below the elbows' policy.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a suitable supply of hand wash sinks and hand gels available.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- We reviewed hand hygiene audit results for a two month period.The scores for these audits were consistently 100%. This meant that 100% of staff observed and audited washed their hands appropriately.

**Nursing staffing**

- The minor injuries unit (MIU) was staffed by band 6 emergency nurse practitioners, with two working on each shift.
- The number of staff on duty was reflective of the duty rota and met the agreed establishment during the time the inspection team was in the unit.
- The MIU had low levels of agency and bank staff usage. The unit manager told us that to mitigate the risks associated with agency or bank staff they would be placed in the urgent care centre at Trafford and a permanent member of staff would be moved to the MIU. This was because there were more permanent staff on duty in the urgent care centre on a daily basis than in the minor injuries unit. We viewed induction checklists completed for agency and bank staff and these were completed fully. These checklists were audited by senior staff within the MIU.
- Staff told us that they had enough time to care for patients and were able to take their breaks when required.
- Nursing staff in the outpatient and diagnostic unit could be rotated between the Trafford and the Altrincham site to cover gaps in staffing. Agency staff could be booked to cover shortfalls in staffing and no clinics had ever been cancelled due to a shortage of nurses. The morning safety huddle identified any gaps in staffing due to sickness or staff training and decisions were made about the allocation of staff for each clinic. Agency staff were generally from the hospital bank staff and had worked in the OPD before
- A consultant we spoke to said that there was sufficient nurse staffing for the OPD clinics.
- Managers at the renal clinic reported that there were occasional staff shortages. Agency staff needed to have training in renal nursing.

# Summary of findings

**Diagnostic imaging staffing**

- There were two radiographers on site Monday to Friday and one to provide cover at weekends. Staff rotated between the Altrincham and Trafford hospital sites.

**Medical staffing**

- The MIU was staffed by Emergency Nurse Practitioners. However the practitioners had access to medical advice by telephoning the urgent care centre at Trafford General Hospital.
- There was a doctor based on the renal unit but they were not there all the time as they would attend other clinics medical assistance could be contacted via the telephone/bleep system if required urgently
- There were three consultants in post and two consultant radiologist vacancies at Trafford and Altrincham. There was a plan in place to mitigate for these shortages by recruiting an additional consultant and introducing a consultant rota across the trust. This was on the risk register with a review date of October 2015. There was no radiologist on site at Altrincham.

**Nutrition and hydration**

- There were facilities for making drinks in the hospital and snacks could be sourced where necessary

**We saw several areas of outstanding practise including**

- The staff approach to patient care and commitment to providing compassionate care to patients.
- The use of reporting radiographers on the Trafford/Altrincham sites provided a rapid reporting service 9.00am -5pm Monday – Friday. X-rays for patients attending A&E or the MIU were reported in in a timely fashion that facilitated diagnosis and discharge.
- The production of dialysate fluid for renal patients on site to reduce costs and the carbon footprint of the unit.
- The training programme and competency assessment for patients who want to dialyse at home. This was supported by renal patients giving advice and support.

**Action the hospital SHOULD take to improve**

**In Minor Injury services:**

- The trust should ensure that all oral medications are clearly labelled with an opened date recorded clearly on the bottle.
- The trust should ensure that the temperatures of the fridges used to store medication are recorded daily.

**In outpatients and diagnostic imaging services:**

- The trust should reduce their waiting times for phlebotomy services at Altrincham hospital
- The trust should consider upgrading the tympanometers in audiology OPD as the equipment is outdated and giving inaccurate results which could affect patient outcomes.
- The trust should look at different ways of working to address the recruitment and retention of radiologists and radiographers.

**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? |
|---|---|---|
| **Minor injuries unit** | Good  | We rated the minor injuries service as 'good' overall because;<br>Incident reporting was good with very low rates of avoidable harm to patients. Staff completed patient's records fully and in legible handwriting. Risk assessments were completed fully and implemented measures to minimise risk to patients.<br>The management of medicines was managed well and staff undertook appropriate checks when administering medication. The facilities and equipment across the service were well maintained.<br>Care and treatment was provided in line with national and best practice guidance. Regular auditing of care and treatment and how effective these were was undertaken. Patients received timely pain relief and were treated with kindness, dignity and compassion and patients and their relatives were involved in their care and treatment.<br>Staff went above and beyond their duty to ensure that patients received compassionate care. The MIU was responsive to patients needs and provided timely access to care and treatment with minimal delays. The service managed complaints well and responded to them in a timely manner.<br>The MIU was well led and staff were clear on the divisional vision. Managers and leaders were visible and staff felt able to approach them.<br>There were areas of innovation including examples of collaborative working with national and local organisations to seek patient's views. |
| **Outpatients and diagnostic imaging** | Good  | We have rated outpatients and diagnostic imaging services as 'good' overall because;<br>Staff were aware of how to report incidents and were confident about raising incidents through the reporting system. There were systems in place to raise awareness about incidents on a daily basis.<br>There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.<br>Staffing levels and skill mix were planned to ensure the delivery of outpatient services at all required times. |

# Summary of findings

When there were shortages of staff this was addressed by senior managers. In the diagnostic imaging service there were consultant vacancies but the trust were aware of these and systems were in place to mitigate any risks.

Outpatient and diagnostic imaging services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account. Their confidentiality and privacy were respected whenever possible.

The renal dialysis unit provided good effective care for their patients and education and support for patients who wanted to dialyse at home. Care was holistic and consideration was given to try to reduce the impact that dialysis had on people's lives. The diagnostic imaging department ran a seven day service which was responsive to patient's needs.

However, the diagnostic imaging department did not have access to information relating to ionising radiation medical exposure regulations (IR(ME)R regulations).

There had been patient complaints about the phlebotomy service. There were long waiting times if the service was not fully staffed. The trust was aware of this and was working to reduce the waiting times.

There was a trust wide out-patient transformation programme group. The aim of this was to develop and implement service standards for OPD clinic. The group also led on improving patient experience across all the trust sites. The standards would deliver a consistent, reliable and quality clinic experience to patients and their families. Altrincham was used as an exemplar site for other services.

# Altrincham General Hospital

## Detailed findings

**Services we looked at**
Minor injuries unit;  Outpatients and diagnostic imaging

# Detailed findings

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## Background to Altrincham General Hospital

Altrincham Hospital is part of Central Manchester Foundation Trust. Altrincham Hospital is situated in the town of Altrincham. The Altrincham is part of the Trafford hospitals group and works closely with the neighbouring Trafford Hospital. The trust serves a population of approximately 226,600 residing in the surrounding area of Trafford, Altrincham and greater Manchester. The hospital does not have any inpatient beds.

During this inspection, the team inspected the following core services:

- Urgent Care services; Minor injuries only
- Outpatients and diagnostic services

## Our inspection team

Our inspection team was led by:

**Chair:** Chief Executive Officer Nick Hulme The Ipswich Hospital NHS Trust.

**Head of Hospital Inspections:** Ann Ford, Care Quality Commission

The team included a CQC inspection manager, seven CQC inspectors, a CQC pharmacy inspector two CQC analysts, a CQC inspection planner and a variety of specialists including: A former medical director; consultant physician, surgeon; surgical, medical, emergency department, senior nurses; an expert by experience (lay members who have experience of care and are able to represent the patients voice) and a clinical governance specialist.

## How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we held about Altrincham Hospital and asked other organisations to share what they knew about the hospital. These included the clinical commissioning

# Detailed findings

groups, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

The announced inspection of Altrincham Hospital took place on 4 and 5 November 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, consultants, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

## Facts and data about Altrincham General Hospital

The new Altrincham hospital opened in April 2015 replacing the Victorian Hospital situated in Altringham.

The new hospital has:

- A nurse led minor injuries unit that sees approximately 60 patients a day
- A renal unit that completes 15,000 dialysis annually
- A range of both paediatric and adult outpatients

## Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Minor injuries unit | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

### Notes

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

# Minor injuries unit

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

## Information about the service

The nurse led Minor Injuries Unit (MIU) was open between hours of 8am until 8pm Monday to Friday and 10am until 6pm Saturday and Sunday, providing care and treatment for children and adults with minor injuries, across the Altrincham of borough and wider Manchester area.

The MIU saw approximately 18,558 patients between March 2014 and March 2015.

There were four consultation rooms in the MIU. There was ample room in the waiting areas where both adults and children waited to be seen.

As part of our inspection we visited the MIU during our announced inspection on 4 – 6 November 2015. We spoke with patients, observed care and treatment and reviewed our records. We spoke with a range of staff at different grades including the Matron for urgent care, the clinical lead for urgent care, the MIU manager, emergency nurse practitioners and receptionist staff. We received comments from our listening events and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

## Summary of findings

We have rated the Minor Injuries Unit (MIU) at Altrincham Hospital as 'good' overall because;

Incident reporting was good with very low rates of avoidable harm to patients. Staff completed patient's records fully and in legible handwriting. Risk assessments were completed fully and implemented measures to minimise risk to patients.

The management of medicines was managed well and staff undertook appropriate checks when administering medication. The facilities and equipment across the service were well maintained.

Care and treatment was provided in line with national and best practice guidance. Regular auditing of care and treatment and how effective these were was undertaken. Patients received timely pain relief and were treated with kindness, dignity and compassion and patients and their relatives were involved in their care and treatment.

Staff went above and beyond their duty to ensure that patients received compassionate care. The MIU was responsive to patients needs and provided timely access to care and treatment with minimal delays. The service managed complaints well and responded to them in a timely manner.

The MIU was well led and staff were clear on the divisional vision. Managers and leaders were visible and staff felt able to approach them.

# Minor injuries unit

There were areas of innovation including examples of collaborative working with national and local organisations to seek patient's views.

## Are minor injuries unit services safe?

Good

We rated the minor injury unit (MIU) as 'good' for safe because;

Staff were aware of how to report incidents and all incidents reported for the MIU in the last year resulted in no harm. Feedback from incidents was provided on an individual staff basis and lessons learned from incidents were distributed to facilitate learning. There had been no recent serious incidents reported for the MIU. The unit did not collect safety thermometer data due to the presenting nature of the patients attending the MIU.

All staff were up to date with their mandatory training. Staff were aware of how to raise and manage safeguarding issues. Infection rates were low with no reported cases of methicillin resistant staphyllocous aureus (MRSA) bacteraemia or clostridium difficile infections for a year. Staff observed appropriate measures to protect patients from avoidable infections. The environment was suitable for the delivery of patient care and equipment was well maintained.

Staff managed medicines well and completed patient records correctly, in legible handwriting. Patient records contained appropriate detail and risk assessments. Records were stored securely.

Nurse staffing levels were adequate to ensure safe patient care.

### Incidents

- All staff had access to the trust wide electronic incident reporting system. All incidents reported for the unit in the last year were documented as resulting in no harm to patients. Staff were aware of the types of incident they should report and told us they felt confident in reporting incidents. Staff told us they always received feedback from incidents.
- There had been no serious incidents reported for the MIU from October 2014 to October 2015.

- Managers shared lessons learned from incidents with frontline staff through learning logs, communications on notice boards and regular staff meetings. We saw evidence of this in minutes of meetings and example learning logs.
- Strategic data from the service showed that staff reported 16 incidents for the MIU between 1 April 2014 and 15 August 2015.
- Staff were aware of duty of candour which for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- The matron responsible for the MIU told us that she had daily access to incident information and reviewed incidents and trends regularly. We saw evidence of this in printed trend and themes analysis which was provided by the clinical effectiveness team based at the Trafford site.
- The clinical effectiveness lead for the Trafford site demonstrated how the division analysed trends in incidents. They also explained how the team were attempting to make the trends and data more user friendly for front line staff to read and interpret.

**Safety thermometer**

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- The unit did not collect safety thermometer data due to the presenting nature of the patients attending the MIU.

**Mandatory training**

- All nursing staff were up to date with their mandatory training which included subjects such as infection control and prevention and life support.
- Staff told us that they were encouraged to attend mandatory training and their managers reminded them when their mandatory training was due for renewal.

**Safeguarding**

- The trust had safeguarding policies and procedures in place. Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Staff showed us how they would access the trust intranet page relating to safeguarding and the trust had an internal safeguarding team who could provide guidance and support to staff in all areas.Staff were able to tell us the name of the designated safeguarding matron who was based at Trafford site but available by telephone to staff in the MIU.
- Training data viewed during the inspection showed that 100% nursing staff working in the MIU had completed level 2 safeguarding training, which was above the trust target of 90%.
- Staff told us that they received comprehensive feedback and support following safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff through their line managers and the safeguarding matron. Monthly safeguarding meetings were also held and were attended by the matron responsible for the MIU. A monthly safeguarding newsletter was also produced and distributed to all staff. This newsletter contained any changes to policy or legislation and also contained the contact details of the safeguarding team.
- There were appropriate referral processes in place for domestic abuse victims.

**Cleanliness, infection control and hygiene**

- The MIU effectively managed cleanliness, infection control and hygiene. Rates of hospital acquired infections within the MIU infections were low. There had been no cases of methicillin resistant staphyllocous aureus (MRSA) bacteraemia or clostridium difficile infections identified in the MIU between April 2014 and April 2015.
- All clinical areas were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment. These were up to date and signed appropriately.
- We reviewed three months of cleaning audits undertaken by the unit and these were consistently scored at 100% compliance.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing

this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance.
- We reviewed hand hygiene audit results for a two month period.The scores for these audits were consistently 100%. This meant that 100% of staff observed and audited washed their hands appropriately.
- The unit had a comprehensive plan for the recent Ebola health alert. This included detailed plans and triggers for staff to identify and isolate suspected cases of the infection as early as possible.

**Environment and equipment**

- The facilities were well maintained with appropriate security measures in place for the protection of patients, staff and visitors. These included swipe access for doors and CCTV.
- The unit did not receive patients brought by ambulance.
- There were four consultation rooms within the unit for nurse practitioners to assess and treat patients.
- There was an x-ray department situated near to the unit.
- There was ample room in the waiting area.
- Appropriate equipment was available in clinical areas including all equipment which could be required specifically for children. Equipment was checked regularly with checklists in use for daily checks of the resuscitation trolleys. We reviewed the records for these checklists for a six month period and all checks were fully completed for the period.
- Portable Appliance Testing was up to date for all electrical equipment we reviewed.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We saw that waste was being segregated and disposed of appropriately.

**Medicines**

- Medicines were managed well and stored securely. We found one bottle of liquid medication which did not have the date it was opened written on it. The manger for the unit discarded the bottle immediately.
- There were appropriate processes in place for ordering, stock reconciliation and discarding of medication.
- Staff locked and secured medication cupboards when they were not in use.
- Fridges used to store medicines were locked. The fridges were used to keep medication only and no other items were present, ensuring minimal risk of contamination to the medication from other sources. The temperatures of the fridges were within expected ranges and records indicated that staff checked and recorded the temperatures on a daily basis. There were three occasions in a three month period where the daily check had not been carried out.
- Records indicated that staff carried out checks on controlled drugs on a daily basis. Controlled drugs were stored in secure cupboards in line with legislation on the management of controlled drugs.
- We observed medication alerts prominently displayed in the staff room and in clinical areas which were used for preparing medication.
- Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Discharge notifications were provided to patients and to their GPs where appropriate.
- Guidelines on the use and preparation of medication were readily available including specific guidelines for children.
- We reviewed five patient group directions (documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions). All five were appropriately documented and authorised. Three of the directions were past their review date; however an appropriate extension was in place and was signed by the relevant senior clinician.
- There were specific drug destruction kits and bins readily available for staff to destroy any medications which were not required.

**Records**

- We reviewed four sets of patient's records and found that all individual care records were up to date and legible. They contained relevant patient information and clear management plans. All care interventions and plans were clearly documented.
- The unit used paper based and electronic, computer based patient records.

**Assessing and responding to patient risk**

# Minor injuries unit

- On admission to the MIU, staff carried out risk assessments to identify patients at risk of specific harm such as self-harm. If staff identified patients susceptible to risks, they placed patients on the relevant care pathway.
- All patients who presented to the unit were seen and triaged by an appropriately qualified and trained nurse. In all four patient records we reviewed the patients had been triaged and seen by a nurse within 15 minutes of arrival to the unit. If a patient's condition was to deteriorate staff told us that they would arrange a transfer by ambulance to an acute hospital site such as Manchester Royal Infirmary.

### Nursing staffing

- The unit was staffed by band 6 emergency nurse practitioners. With two working on each shift.
- The number of staff on duty was reflective of the duty rota and met the agreed establishment during the time we were in the unit.
- The unit had low levels of agency and bank usage. The unit manager told us that to mitigate the risk of agency or bank staff they would be placed in the urgent care centre at Trafford and a permanent member of staff would be moved to the minor injuries unit. This was because there were more permanent staff on duty in the urgent care centre on a daily basis than in the minor injuries unit. We viewed induction checklists completed for agency and bank staff and these were completed fully. These checklists were audited by senior staff within the MIU.
- Staff told us that they had enough time to care for patients and were able to take their breaks when required.

### Medical staffing

- The unit was staffed by Emergency Nurse Practitioners. However the practitioners had access to medical advice by telephoning the urgent care centre at Trafford General.

### Major incident awareness and training

- The unit was not part of the trusts wider response team to major incidents.
- The trust had a major incident policy in place which was available on the trust intranet site. Staff were able to tell us how they would access it and showed a good understanding of the policy.

## Are minor injuries unit services effective?
(for example, treatment is effective)

Good

We rated the MIU as 'good' overall for effective because;

The MIU provided effective care and treatment that followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM). The service participated in local clinical audits but did not participate in national CEM audits. Action plans were formulated following local audits and progress on these actions were monitored.

Evidence based pathways were in use and staff placed patients on these pathways as soon as possible. The trust's policies and procedures reflected national guidelines and best practice. Patients' nutritional and hydration needs were identified and addressed appropriately and there was access to food and drink in the MIU. Patients received timely analgesia.

Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team. Staff sought appropriate consent from patients before delivering treatment and care and appropriately considered the Mental Health Act where relevant.

### Evidence based care and treatment

- The MIU used both National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to guide the care and treatment they provided to patients.
- A range of evidence based clinical care pathways were available and put in place for patients with relevant conditions. These pathways included prompts and treatment steps for staff to follow. Patients were placed on appropriate pathways as soon as their condition was diagnosed which ensured that they received timely and appropriate interventions. The pathways were regularly reviewed on a trust wide basis and reflected current guidance from NICE.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.

# Minor injuries unit

- The MIU was meeting most of the requirements set out within the document 'unscheduled care facilities-minimum requirements for units which see the less seriously ill or injured'.

**Nutrition and hydration**

- The MIU had facilities for offering patients drinks.

**Pain relief**

- In the A&E survey 2014 urgent care services across the trust scored about the same as other trusts in England for all indicators relating to timely access to pain relief.
- We reviewed ten patients' records and found that all four patients presenting with pain received timely analgesia.

**Patient outcomes**

- The MIU had not participated in the national Royal College of Emergency Medicine (CEM) audits. CEM audits allow trusts to bench mark their practice against national best practice and encourage improvements. The clinical effectiveness lead told us that they did not participate as the trust had been advised that the unit did not meet the criteria to participate. The unit met the criteria for inclusion in one of the current CEM audits; VTE risk in lower limb immobilisation in plaster cast'.
- The unplanned re-attendance rate for urgent care services within the trust within seven days was consistently higher (worse) than the England average between September 2014 and October 2015.

**Competent staff**

- Records reviewed showed that 100% of nursing staff within the MIU had received their annual appraisal this was higher than the trust target of 90%. The overall appraisal rate for the Trafford division including Altrincham Hospital for staff including allied health professionals and excluding medical staff was 84%. This was again below the trusts target of 90%. An appraisal gives staff an opportunity to discuss their progress and any concerns or issues with their manager.
- Staff were provided with regular supervision with their mangers and colleagues. They were also supported and undertook supervision with their consultant colleagues based at Trafford Urgent Care Centre.
- Some of the nurse practitioners rotated between the urgent care centre at Trafford and the minor injury unit.

**Multidisciplinary working**

- There was effective communication and collaboration between multidisciplinary team members within the urgent care services. Staff within the unit communicated effectively with clinicians on other sites to seek advice and guidance and worked with allied health professionals to facilitate patient discharges. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.

**Seven day services**

- The MIU was open to patients between the hours of 8am until 8pm Monday to Friday and 10am until 6pm Saturday and Sunday. The Trafford Division had processes in place for staff to follow in the event that patients attended the hospital for minor injury care outside of the unit's opening hours.
- The x-ray department had the same opening hours as the MIU.
- Pharmacy services were not available seven days a week, but a pharmacist was available on call out of hours. The MIU held a stock of medications which were frequently required such as antibiotics and analgesia that staff could access out of hours.

**Access to information**

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission through to discharge. This meant staff could access all the information needed about the patient at any time.
- Staff produced discharge summaries and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might

**Consent, Mental Capacity Act and DOL's**

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate.

# Minor injuries unit

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff gave us examples of when patients lacked the capacity to make their own decisions and how this would be managed.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards.

## Are minor injuries unit services caring?

Good

We rated the MIU as 'good' for caring because;

Staff treated patients with kindness, dignity and respect. Staff provided care to patients while maintaining their privacy, dignity and confidentiality. Patients spoke very positively about the way staff treated them. They told us they were involved in decisions about their care and were informed about their plans of care.

Staff went above and beyond their duty to ensure that patients received compassionate care. One example of this was staff staying after their shifts to support patients and arranging a hot meal for a patient who lived alone.

The patient tracker system used by the trust to measure patient experience showed that most patients were happy with the care they received in the MIU. Staff took their time to support patients and ensure that they knew what was happening. We heard of and observed examples of outstanding care. Staff showed that they understood the importance of providing emotional support for patients and their families. Patients and their families told us they felt well supported and involved as partners in their care and treatment.

**Compassionate care**

- Urgent care services across the trust scored the about the same as other trusts for all standards related to compassionate care in the 2014 A&E survey.
- The Trafford Division also used a 'patient tracker' system to measure patient experience. This system was based on touch screen stations at the exit and entry points to the unit. These stations took patients through a series of questions about their care and treatment and allowed them to leave anonymous feedback relating to their experiences. An overall score was then calculated and this could be accessed on a daily basis by senior managers and the unit manager. We reviewed seven days scores from patients and this data showed that all patients surveyed were happy with the care they had received when they attended the unit. Information from this initiative was then fed through to matrons and divisional managers in monthly quality reports and dashboards.
- We observed staff treating patient with kindness and compassion. Staff took time to interact with patients and communicated with patients in a compassionate manner.
- We observed that doors were closed in order to maintain confidentiality.
- We spoke with two patients, who gave us positive feedback about how staff treated and interacted with them.
- We saw that staff interacted with patients regularly.
- Staff and patients gave us examples where staff had gone above and beyond their duty to provide outstanding care to patients. Staff members and patients told us that staff regularly stayed after their shift finish times to care for patients.
- One recent example of this was that staff stayed over an hour after their shift finished with a child and their parent waiting for an ambulance to arrive to transport them to another site. The staff members stayed to ensure that the patient received pain relief and their relatives were supported.
- Staff and patients told us of examples where staff had gone above their duty to ensure patients received compassionate care. One example of this was staff ensuring that a patient who was waiting for relatives received a hot meal in the evening. The patient lived alone and ordinarily would have had help to prepare a meal at home but had missed this help due to attending the unit.

# Minor injuries unit

**Understanding and involvement of patients and those close to them**

- Staff respected patients' rights to make choices about their care and treated patients as partners in their care. Staff communicated with patients in a way they could understand.
- Patients told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as discharge information leaflets specific to their condition.
- Patients told us staff fully explained the treatment options to them and allowed them to make informed decisions.
- Staff identified when patients required additional support to be involved in their care and treatment, including translation services. Staff were able to tell us how they would access translation services including sign language interpreters.

**Emotional support**

- Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives. Patients and relatives told us that staff supported them with their emotional needs.
- Staff confirmed they could access management support or counselling services after they had been involved with a distressing event.
- We were told of an incident where a member of the public had suffered a collapse outside the unit. On this occasion staff left the unit to assist in the care of the member of the public. The relative of this individual was not able to travel in the ambulance with the patient. Staff from the unit brought the patients relative into the unit and provided them with emotional support and hot drinks until transport arrived to take them to be with their relative.

**Are minor injuries unit services responsive to people's needs?**
(for example, to feedback?)

Good

We rated the MIU as 'good' for responsive because;

The MIU service was well organised and had provisions in place to meet the needs of the local population. Patients were kept well informed of all stages of their treatment and care. Information including discharge advice was readily available for patients in a variety of formats, which could be adapted to individual needs.

Access and flow within the MIU was good with patient experiencing minimal delays. Patients accessing urgent care services across the trust spent less time in services as compared to other trusts in England, however a higher number of patients re attended urgent services within seven days as compared to the England average.

Complaints were managed well and responded to in a timely manner.

**Service planning and delivery to meet the needs of local people**

- The MIU planned and delivered their services to meet the needs of people using them.
- The waiting area was adequate with enough seating for patients.
- There were adequate facilities to allow access and use by disabled patients. Including wide corridors and rails in disabled bathrooms.

**Meeting people's individual needs**

- The MIU was responsive to patients needs and organised their services to meet the needs of the patients they treated.
- Information leaflets about services available and discharge advice were readily available in all areas. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. Staff told us that they could access a language interpreter if needed and were able to show us how they would do this. They also had access to language line which is a translation facility. The patient tracker system was available in 16 languages.
- Staff received training in the care of patients with dementia. Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff were aware of how to assess if reasonable adjustments needed to be made for patients with a disability.

# Minor injuries unit

- Access to psychiatric support was readily available from the RAID team and staff told us they did not have any issues accessing this support for patients.

**Access and flow**

- The number of patients leaving urgent care services without being seen across the trust was consistently higher than England average from July 2014 to April 2015. Unfortunately the trust were unable to provide these figures for the Altrincham site specifically.
- The total time patients spent in urgent care services across the trust was consistently lower than the England average from November 2014 to May 2015.
- All patients we spoke with told us they were seen quickly and expressed no concerns about waiting times.
- A transfer policy was in place and this offered guidance on which escorts were required to accompany patients to other hospitals.
- There was a divisional escalation policy in place. This policy guided staff on steps to take if patients were in the unit for longer than expected or were waiting excessive times for an inpatient bed. The policy included clear steps for staff to take and we observed the shift coordinators following this process correctly.
- A winter pressures plan was in place for the Trafford Division and staff within the MIU were aware of this plan.
- We reviewed four records and all four patients were seen within their allotted triage time category.
- Urgent care services across the trust scored about the same as other trusts in England for all three standards relating to access to timely care in the 2014 A&E survey.

**Learning from complaints and concerns**

- Information on how to raise a complaint and contact details of the PALS team was prominently displayed around the MIU.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient effectively.
- The trust recorded complaints on the trust-wide system. The unit manager and urgent care matron were responsible for investigating complaints relating to the MIU.
- We reviewed three complaint records from the period of April 2014 to April 2015 for the Trafford Hospitals Urgent care Division. We saw that all three complaints had been appropriately documented and tracked. The complaints had been responded to in a timely manner in two cases; in one case the response was delayed. In this case the delay had been clearly communicated to the patient and apologies had been offered.
- Information about complaints was discussed during staff meetings to facilitate learning. Key lessons learned from complaints were formulated into lessons learned and 'hot topics'.

## Are minor injuries unit services well-led?

Good

We rated the MIU service as 'good' for well led because;

The MIU service was well led at local and divisional level. The divisional vision was embedded and staff were clear what this vision was. There were robust governance frameworks and managers were clear about their roles and responsibilities.

Risks were appropriately identified, monitored and there was evidence of action taken where appropriate. There was clear leadership throughout the service and staff spoke positively about their leaders. Managers were visible and staff felt able to able approach them.

Staff told us the culture within the service was open and they felt very well supported. We saw evidence of good staff engagement particularly in relation to the recent changes to services at the Trafford site. Managers made efforts to engage the public when planning services and worked collaboratively with national charities and local carers groups.

There were areas of innovation and leaders within the services were working to continually improve services.

**Vision and strategy for this service**

- The Trafford Hospitals division had a formal vision which was prominently displayed around the hospital and MIU. Staff were aware of the vision and were able to tell us what the vision was and how they felt they applied the vision to their daily work.

**Governance, risk management and quality measurement**

# Minor injuries unit

- There was a robust governance framework within the urgent care services. Managers were clear about their roles in relation to governance and they identified, understood and effectively managed quality, performance and risk.
- A risk registers was in place for the MIU. We saw evidence that this register was regularly reviewed, updated the risks were escalated where appropriate. We reviewed action plans which were in place to address these risks. There was a system in place that allowed managers to escalate risks to divisional meetings.
- Audit and monitoring of key processes took place in the MIU to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives.
- There was a monthly clinical governance meeting held for the Trafford Hospitals Division and we saw minutes from this meeting. We saw evidence in these minutes of key risks being discussed and actions recommended.

**Leadership of this services**

- The leadership within the urgent care service reflected the vision and values set out in the divisional vision. Staff spoke very positively about leaders within the services. Leaders were visible, respected and competent in their roles.
- There were clearly defined and visible leadership roles across the MIU and the Trafford Hospitals Division. Staff told us that their mangers and senior leaders were visible and approachable. Staff told us they frequently saw senior managers in the MIU.
- The unit manager was visible during our visit.

**Culture within this services**

- Staff told us they felt respected and valued.
- All staff told us that they felt secure raising a concern or issue with their managers.

**Public engagement**

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The Trafford Hospitals Division worked closely with the stroke association, AGE UK and the Trafford cares unit to ensure they took patients and carers views when planning service.

**Staff engagement**

- Staff told us they felt well supported and received regular communication from their managers.
- Staff participated in team meetings on a monthly basis.

**Innovation, improvement and sustainability**

- Leaders within the service were working to continually improve services. We saw evidence in business plans and strategic objectives that leaders assessed the sustainability of these plans and improvements.
- The Trafford Hospitals Division and MIU had implemented innovative initiatives and collaborations. One example of this was the introduction of the patient tracker system to monitor the experience of patients using the unit.
- The Trafford Hospitals Division worked collaboratively with the stroke association, AGE UK and the Trafford cares unit to improve services.
- A hot topic initiative was in place where information on a specific topic was prepared and distributed to all clinical staff on a monthly basis.

# Outpatients and diagnostic imaging

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

## Information about the service

Altrincham hospital opened in April 2015 and replaced the Victorian hospital which was situated close by. All the existing services were transferred to the new building which provides a range of outpatient services. The main outpatient department at the hospital is located on the first floor of the hospital. There is also a 20 bedded renal dialysis unit on the second floor of the hospital.

There are no overnight inpatient beds at Altrincham hospital

Altrincham hospital and Trafford hospital work closely together. Outpatient staff and diagnostic imaging staff rotate between the sites. There are shared policies and protocols across both the sites.

In 2014 there were 116,800 outpatient appointments across the two sites. The outpatient department at Altrincham offers clinics in a range of services including ophthalmology, respiratory, haematology, orthopaedics and ear nose and throat. Audiology services for adults and children are located at Altrincham.

The diagnostic imaging department provides diagnostic services to the patients including general x-ray and ultrasound services.

We visited the outpatient and diagnostic imaging departments and the Renal Dialysis Unit on 5 November 2015. In outpatients and radiology we spoke with one consultant, one junior doctor, a nurse manager, two radiographers, two phlebotomy staff and nine patients. On the renal clinic we spoke to two ward managers and six nurses.

# Outpatients and diagnostic imaging

## Summary of findings

We rated outpatient and diagnostic imaging services at Altrincham Hospital as 'good' overall because;

Staff were aware of how to report incidents and were confident about raising incidents through the reporting system. There were systems in place to raise awareness about incidents on a daily basis.

There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.

Staffing levels and skill mix were planned to ensure the delivery of outpatient services at all required times. When there were shortages of staff this was addressed by senior managers. In the diagnostic imaging service there were consultant vacancies but the trust were aware of these and systems were in place to mitigate any risks.

Outpatient and diagnostic imaging services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account. Their confidentiality and privacy were respected whenever possible.

The renal dialysis unit provided good effective care for their patients and education and support for patients who wanted to dialyse at home. Care was holistic and consideration was given to try to reduce the impact that dialysis had on people's lives. The diagnostic imaging department ran a seven day service which was responsive to patient's needs.

However, the diagnostic imaging department did not have access to information relating to ionising radiation medical exposure regulations (IR(ME)R regulations). There had been patient complaints about the phlebotomy service. There were long waiting times if the service was not fully staffed. The trust was aware of this and was working to reduce the waiting times.

There was a trust wide out-patient transformation programme group. The aim of this was to develop and implement service standards for OPD clinic. The group also led on improving patient experience across all the trust sites. The standards would deliver a consistent, reliable and quality clinic experience to patients and their families. Altrincham was used as an exemplar site for other services.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging services as 'good' for safe because;

There were clear processes for reporting and investigating incidents and the learning from incidents was shared. Cleanliness and hygiene in all the departments was of a good standard. Personal Protective Equipment (PPE) was available and we saw staff using it. There was a process for non-compliance of the hand hygiene audits.

Electronic patient records system (EPS) was available in most of the out-patient clinics and was comprehensive while only giving full access to those who needed it ensuring confidentiality. Paper records were available if necessary.

Staff were aware of the trust safeguarding policies and procedures to protect children and adults. There had been a recent incident in the out-patient department and a decision had been made that all staff should be trained to level three in safe-guarding. This had recently been implemented and there was a program in place to ensure all staff received the training as part of the rolling programme of mandatory training

Staffing levels were adequate to meet the needs of the service and staff could be rotated between sites to cover clinics with staffing shortfalls. There were two consultant radiologist vacancies and the trust were working to mitigate and risks for this shortfall.

### Incidents

- Staff told us that there was a good culture of incident reporting with timely feedback to staff to ensure lessons were learned. There was an incident reporting committee and any incident concerning patients and learning points were fed back to staff. We spoke to staff who said they knew how to report an incident on the trust system.
- Data provided by the trust showed that incident reporting was at a level expected of similar site sites such as Altringham Hospital
- There was a morning huddle for OPD staff. Any incident from the previous working day was raised and remained active at the huddle for two weeks.
- We spoke to a consultant who understood the duty of candour; this ensures that staff in hospitals are open and honest with the people who use the services. He said that patients needed to know what actions were taken to prevent mistakes happening again.
- The trust produced a medicines safety dashboard that was available on the trust intranet. This highlighted medication error incident reports and the actions and processes that needed to be put in place to mitigate harm and to try to prevent further incidents.
- Diagnostic imaging staff were aware of online incident reporting. They received feedback about incidents and near misses at team brief. The staff understood the duty of candour and immediately apologised if anything went wrong.
- In the diagnostic imaging service a continuing professional development manager followed up any training needs required if there was an incident involving radiation. This included a one to one with the staff member.

### Cleanliness, infection control and hygiene

- All the OPD areas of the hospital were visibly clean. Trafford hospitals used in house cleaners who were very responsive. PPE was available and we saw staff using it. The curtains in the OPD were disposable. All were within date.
- There were regular hand hygiene audits; these were undertaken with a sample of staff clinical and non-clinical. If hand hygiene compliance fell below 85%, daily hand hygiene audits would take place for a period of time specified by the matron. Any non-compliance was recorded as an incident for the attention of the head of nursing.
- The renal dialysis unit was visibly clean throughout and had two isolation rooms, both of which were ensuite, for the use of patients who had an infection. There was 100% compliance with the hand washing audit on the renal dialysis unit. There was an infection control board that displayed information about hand washing and infection control for patients and staff. There had been no hospital acquired infections on the clinic. The diagnostic imaging unit was visibly clean, hand gel was available in appropriate areas and the containers were full. PPE was available.

# Outpatients and diagnostic imaging

**Environment and equipment**

- The building at Altrincham was new; it was opened in April 2015. It was bright and airy with spacious waiting areas. There was a separate children's waiting area and play area. There were boxes of toys that were clean and tidy; however there were not many toys available. There were no children's clinics running on the day we visited.
- We saw equipment with "I am clean" stickers on. These were dated and showed equipment was ready to use. We saw that weighing scales had been recently calibrated. We checked resuscitation trolleys on the first and second floors of the hospital. All were checked daily; all items were sealed and were within date. This was documented.
- The renal dialysis unit was spacious and there were a number of bays of different sizes.
- Equipment on the renal dialysis unit was checked daily by staff from the trust. Pieces of equipment had "I am clean" stickers to inform staff that equipment was ready for use.
- The diagnostic imaging department at Altrincham had a bright clean and open environment. There was good access for patients who were disabled. There was a resuscitation trolley in the minor injuries unit (which was adjacent to diagnostic imaging) which was checked and up to date. The diagnostic imaging equipment at Altrincham was new, the maintenance and servicing was in date. Quality assurance systems were in place and were completed by a radiographer.
- All dose reference levels relating to radiological exposures were directly recorded onto the computerised radiology information system (CRIS). These levels were reported at the clinical radiology radiation protection meetings. The minutes from the meeting held in October 2015 recorded that the doses at Altrincham were satisfactory. This meant that radiology staff were not receiving doses of unsafe radiation.

**Medicines**

- Medicines at Altrincham OPD were stored in locked cupboards in the clinics. Eye drops were stored in fridges; the temperatures were monitored and recorded. Fridge temperatures were within the required range. A limited amount of medicines were available in the OPD, however, patients were usually issued with a prescription when attending appointments in outpatients. There were no controlled drugs in the OPD.
- Medicines were stored in a locked cupboard on the renal unit; there were no controlled drugs.

**Records**

- Most of the out-patient department (OPD) clinics at Altrincham and Trafford used an electronic patient record. (EPR) These records were scanned on demand for new patients attending OPD and patients attending the hospital for an elective procedure. The records were comprehensive though some users only had access to specified sections of the record. This meant that all the record was not available to every user which maintained confidentiality. Information in the EPR could not be altered by the users.
- The trust used a Chameleon outpatient views system which allowed users to view information from different systems.
- Some clinics were not using the EPR used paper records; these were the eye clinics and clinics where surgery had taken place at another site. If a patient was given an urgent appointment their records may not have been scanned in time for the clinic and the paper records were sent from the referring hospital. If these were not available a ward discharge letter or the clinical letter from the last OPD appointment was printed out. The paper records for the eye clinics arrived daily from the eye hospital; records were returned on the same transport.
- We spoke to a consultant in one of the clinics. He said that the EPR system was much better than the paper records and it ensured a safer service for the patients.
- Staff said that the EPR system reduced duplication of pathology tests and radiology interventions.
- There were paper records on the renal dialysis unit. These were kept at the end of the patient's bed during treatment and then securely stored.

**Safeguarding**

- As well as safeguarding training, staff had updates on safe-guarding from the hospital lead for safe-guarding**.** Staff we spoke to understood safe-guarding issues and how to report them
- Following an incident, it was agreed that all OPD staff at Trafford /Altrincham would be trained to level three in safeguarding. At the time of our inspection, 29% of the staff had received this training which was on-going. Staff on the renal unit were trained to level three in safeguarding.

# Outpatients and diagnostic imaging

- The morning core huddles identified any patients who had safe-guarding issues or were vulnerable who were attending the OPD that day.
- There was a monthly team brief for safeguarding issues.
- The renal dialysis unit had a link nurse for safe-guarding.

**Mandatory training**

- In OPD 100% of staff appraisals were complete and 95% of the staff had completed their mandatory training. The trust target for mandatory training was 90%.
- Mandatory training was on a rolling programme and was by e-learning or practical learning for example manual handling and life support training. Staff were given time before and after clinics to complete their training.
- All the staff on the renal dialysis unit had completed their appraisals and there was 100% compliance with mandatory training.

**Assessing and responding to patient risk**

- Staff had clear guidance to follow if a patient's condition deteriorated while they were in the OPD. Resuscitation equipment was available in the OPD and was ready for use.
- Morning core huddles where any risks were discussed were documented and signed off by the lead nurse. Agency staff were included in the huddle.
- There was a checklist for emergency equipment.
- The EPR system flagged up patient alerts such as allergies and safe-guarding. These could not be bypassed until they were acknowledged by the person accessing the record.
- Patients attending the renal dialysis unit were assessed using strict criteria as there was not always a doctor on site. In an emergency patients would be transferred using the emergency 999 service. Early warning scores were used to monitor patients having dialysis, if there were any problems staff could speak to a doctor at the acute renal unit at Manchester Royal Infirmary.
- We observed a staff handover on the renal dialysis unit. There was good information sharing and any risks were highlighted.
- All the patients attending the renal dialysis unit had a risk assessment. There were harm free boards on the walls where the risk assessment for each patient was documented on the board. Patient names were hidden to ensure confidentiality. Staff could see at a glance the risks for each patient.
- Patients who were most at risk were given a bed closer to the nurses' station for their treatment. Pressure mattresses were available for those at risk of pressure sores. There was patient focused rounding and staff spoke to patients while they were undergoing treatment so they could raise issues and concerns.

**Nursing staffing**

- Staff could be rotated between the Trafford and the Altrincham site to cover gaps in staffing. Agency staff could be booked to cover shortfalls in staffing and no clinics had ever been cancelled due to a shortage of nurses. The morning safety huddle identified any gaps in staffing due to sickness or staff training and decisions were made about the allocation of staff for each clinic. Agency staff were generally from the hospital bank staff and had worked in the OPD before
- A risk had been raised on the risk register that nursing levels could lead to cancelled clinics and increased levels of staff sickness due to stress. Controls were put in place and the review date was November 2015.
- A consultant we spoke to said that there was sufficient nurse staffing for the OPD clinics.
- Managers reported that there had been a significant amount of long term sickness in the OPD that was being addressed with support from HR.
- Managers at the renal dialysis unit reported that there were occasional staff shortages. Agency staff needed to have training in renal nursing.
- No children's clinics took place at Altringham hospital therefore paediatric trained nurses were not required.

**Diagnostic imaging staffing**

- There were two radiologists on site Monday to Friday and one to provide cover at weekends. Staff rotated between the Altrincham and Trafford hospital sites.

**Medical staffing**

- There was a doctor based on the renal unit but they were not there all the time as they would attend other clinics. Medical assistance could be contacted via the telephone/bleep system if required urgently.
- There were three consultants in post and two consultant radiologist vacancies at Trafford and Altrincham. There was a plan in place to mitigate for these shortages by

recruiting an additional consultant and introducing a consultant rota across the trust. This was on the risk register with a review date of October 2015. There was no radiologist on site at Altrincham.

**Major incident awareness and training**

- There was a major incident plan for the trust and a detailed business continuity plan. The trust had an emergency planning officer.
- If patients could not attend the renal dialysis unit because of poor weather conditions, staff would liaise with their GP's to prescribe and deliver appropriate medicines until the local mountain rescue team could bring patients to the hospital.
- All staff would attempt to reach the hospital to cover the shifts in poor weather.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There was a trust wide out-patient transformation programme group. Staff had completed a baseline assessment of their service. The information from the assessment had assisted in the development of quick wins and long term plans to improve the service.

Diagnostic imaging services were available seven days a week; this supported the minor injuries unit. There was good multi-disciplinary working in OPD and on the renal dialysis unit

Staff worked to relevant clinical guidelines which were available on the trust intranet when needed.

**Evidence-based care and treatment**

- Care and treatment followed appropriate national guidance. Guidance and guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges and other best practice guidelines were available to staff via the intranet.New guidelines and changes were circulated to staff. A number of services in OPD participated in local audits.
- The renal service worked to NICE guidelines. They participated in national and local audits and were involved in research trials.
- The reporting of the dose reference levels relating to radiological exposures to the radiation protection advisor via the clinical radiology radiation protection meeting was in line with good practice guidance.
- We asked to see the ionising radiation medical exposure regulations (IR(ME)R) with lists of procedures but the staff could not locate the file. The staff said it would be on the staff intranet site but they could not find it during our visit.
- We did not see any local rules near to the control panel. The local rules should be in writing and are appropriate to the radiation risk and the nature of any procedures undertaken in that area. This is part of the ionising radiations regulations 1999.
- We saw there was a list of examination protocols dated November 2012. There was no review date and the document should be reviewed every three years.

**Pain relief**

- Following feedback from patients at the renal dialysis unit, staff realised that the first assessment that they made about patients pain was good but that they did not review this. They had introduced a review as part of the patients' risk assessment.
- Pain relief was available at the renal dialysis unit though it was the patients GP who was responsible for the prescribing of their medicines.

**Patient outcomes**

- There was a trust wide out-patient transformation programme group that reported to the trust board. The programme objective was to develop and implement service standards for OPD clinics. The group also led on improving delivery and patient experience across all the trust sites. The standards would deliver a consistent, reliable and quality clinic experience to patients and their families.
- The OPD at Altrincham had completed a baseline assessment of all the out-patient teams as part of the transformation process. They had scored 100% for the non-cancellation of clinic appointments at less than four weeks' notice and 98% on choice of where care was delivered. The areas of poor performance were about information received before the clinic appointment, the OPD scored 70% and staff support when attending clinic, this scored 66%.
- The baseline audit provided both quick wins for the OPD and long term plans to improve services. There was to

be an initial focus on diabetes, respiratory and orthopaedic clinics to improve productivity and efficiency and delivery plans had been developed for these services.
- Following a review of patients who had undergone dialysis, who were at risk of falling following treatment .An action where they were asked to wait for 30 minutes before they went home had been put in place; this had reduced the number of falls.
- Robust systems were in place for onward referral of patients with signs of cancer on any diagnostic imaging test.

**Competent staff**

- There was a continuing professional development manager for staff.
- Every three months, in OPD, there was staff training in medical devices. We were shown a record of the training and those who had attended the training.
- There was a hot topic education programme for staff and information was displayed around the hospital. There had been revalidation drop in events for staff. One of the hot topics was about revalidation. Staff had found this useful.
- Monthly meetings for OPD staff reviewed complaints, incidents, any feedback on NHS choices and any learning points discussed. The minutes of the meetings were available in the coffee room for all staff.
- A risk had been identified that out-patient staff were not trained in paediatric resuscitation; it was planned that all staff will be trained in basic paediatric life support by early 2016. This was to be prioritised at Altrincham as there was no resuscitation team at Altrincham.
- Some of the reception staff were to be offered customer care training.

**Renal unit**

- Nursing staff at the renal dialysis unit were on a rotation through the renal unit at Manchester royal infirmary for more acutely ill patients. Staff had their competencies assessed in practice by senior staff. There was good staff development and some staff were funded for additional specialist training.
- Following training and a competency assessment, some band three staff were able to dialyse patients.
- Each member of staff had a link role which was part of the appraisal process e.g. there were link nurses for medical devices, dementia, and pressure mattresses.
- Staff at the renal dialysis unit had regular meetings. The notes of the meetings were displayed in the staff room.

**Multidisciplinary working**

- Multi-disciplinary working (MDT) working was good with occupational therapists and physiotherapists in the OPD.
- There was good MDT working with the vascular access nurse for those patients who needed a fistula for dialysis (a fistula provides reliable access to the patient's blood stream for dialysis)
- There was access to a dietician for renal patients.
- Some patients from the renal dialysis unit had reported that they had fallen at home; this was as a result of their treatment. Staff from the falls clinic at Trafford had worked with the patients to reduce the risk of falls when they left the unit.

**Seven-day services**

- There was capacity at Altrincham to develop out of hours and seven day working.
- The manager of the phlebotomy service was working to increase the capacity of the service, Saturday working was being considered.
- The renal dialysis unit ran a six day service Monday-Saturday.
- There was a trust plan to move to consultant led seven day working. The service needed to ensure that there was enough diagnostic imaging sub-speciality expertise for seven days before this could happen.
- Diagnostic imaging services at Altrincham were 8am -8pm, Monday-Friday. At weekend the service was 9.30am-6pm.These were the same hours as the MIU. The ultrasound service was five days per week by appointment only.

**Access to information**

- Staff had access to the trust intranet for information. There was a radiology intranet page for staff.
- The electronic patient record contained imaging and test results and were available to staff during a consultation or treatment.
- There were two individual picture archiving and communication systems (PACS) across the trust. One of them was at the central site and the other at Trafford/ Altrincham. As a result there were multiple patient image transfers between the sites on a daily basis so images may have been at the wrong site for viewing or

for reporting. This meant that there could have been a delay in patient treatment. An interim system had been put in place which allowed viewing of the past imaging history across the trust. This was recorded on the risk register.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Staff would seek advice and guidance from their line manager if a patient lacked capacity to advise them regarding the processes for making decisions about their care. The daily core huddle identified those attending clinic who were vulnerable or lacked capacity.
- The phlebotomy staff we spoke to understood the Mental Capacity Act and about the principles of consent and used this information when patients with dementia or reduced cognitive function attended for phlebotomy services.

## Are outpatient and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging services as 'good' for caring because;

Outpatient and diagnostic imaging services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account. Their confidentiality and privacy were respected whenever possible.

Staff on the renal dialysis unit provided holistic care and were actively involved with patients and those close to them in all aspects of their care and treatment.

Systems were in place in diagnostic imaging to ensure that frail older people from nursing homes were seen in a timely manner and were returned home without delay.

Patients said that information and leaflets about their treatment and care were not always available.

**Compassionate care**

- Throughout our inspection, we saw patients being treated with dignity and respect. Staff listened to patients and responded to them in a positive way.
- 86% of patients who took part in the friends and family test said they would recommend the OPD and 76% of staff recommended the hospital for care.
- There was a reception desk for booking in on arrival at OPD. This was a generalised area for all the OPD clinics and patients were requested to wait a distance behind patients booking in to ensure confidentiality. Patients were called into clinics by name but patients we spoke to said that staff did not always introduce themselves by name.
- The reception area on the ground floor did not provided privacy for patients checking in and making enquiries. Patients confirmed that did not always have privacy when speaking to a receptionist.
- Chaperones were available to support patients during procedures if necessary. Policies regarding chaperones were available on the intranet. Patients we spoke to said that they had been offered a chaperone.
- Some patients attending for dialysis said they felt socially isolated because of the length of their treatment. Staff were aware of this and telephoned patients at regular intervals particularly if they had concerns about them. The hospital chaplain also visited the renal unit on a regular basis to support patients who felt isolated. Patients at the renal dialysis unit were asked what magazines they would like in the waiting room. These were then supplied by a local charity.
- The cubicles in the diagnostic imaging department ensured privacy and dignity for patients changing out of their clothes.
- Patients from nursing homes were prioritised for x-rays and the patient transport service waited until their treatment was finished and returned them to the nursing home. This meant that frail older people were not waiting for return transport.

**Understanding and involvement of patients and those close to them**

- We spoke with seven patients who said that staff explained their care and treatment to them but they received little written information or leaflets about their treatment. We did not see any written information or leaflets during our visit.
- Most patients knew who to contact if they were worried about their treatment or condition.

# Outpatients and diagnostic imaging

- Staff on the renal unit worked with relatives and patients to support them through their treatment. During our inspection a patient did not attend for treatment, staff telephoned a relative who agreed to bring the patient in for treatment.

**Emotional support**

- Staff were sensitive to the needs of patients who were anxious or distressed about their appointment.
- Some of the staff in out-patients had received advanced communication skills training in how to communicate bad news.
- Staff at the renal dialysis unit had a holistic view of their patients and worked with them to try to reduce the impact that dialysis had on their lives. Many patients had attended for many years and patient's birthdays were celebrated on the clinic.

## Are outpatient and diagnostic imaging services responsive?

Good

We rated outpatient and diagnostic imaging services as 'good' for responsive because;

Few clinics were cancelled and if they were, a new appointment was given in a timely manner. There were rapid access clinics and GP's worked with consultants to ensure that patients were seen urgently if necessary. There were nurse led clinics and specialist nurse support in clinics for a number of specialities in the OPD including diabetes, rheumatology and ear nose and throat. The failure to attend rates for clinics were less than the England average.

The diagnostic and imaging service worked with the minor injuries unit to ensure that patients received their x-rays in a timely way.

The renal unit had a training programme for patients to train them to dialyse at home and a shared care service for patients who may not have had space at home or needed some input from nursing staff.

Patients attending the phlebotomy clinic, especially early in the morning, sometimes had to wait two hours for blood tests. This had resulted in patient complaints, the trust were looking at various solutions to address this.

**Service planning and delivery to meet the needs of local people**

- There was information available about the length of clinic waiting time outside each clinic. The names of the doctors, nurses and other staff who were running each clinic were also displayed. There were a number of nurse led clinics and specialist nurses were available in consultant clinics.
- Consultant clinics worked on a 42 week rota to take into account training, annual leave and study days. If a consultant missed a clinic they had to make time for another clinic in the schedule. This meant that few clinics were cancelled and if they were, patients were given a new appointment in a timely manner.
- There were rapid access clinics at the hospital ensuring that patients were seen in a timely way. GP's could ring and book appointments for their patients
- The lead nurse in OPD was the equality and diversity champion and had set up a road show for hospital staff. The hospital had run a master class on the equality act and shared parental leave.
- The renal dialysis unit produced its own dialysate (the fluid used in the dialysis process). They were able to vary the electrolyte levels in the fluid to meet the clinical needs of the patients. The production of their own dialysate the unit significantly reduced their carbon foot print as large volumes of fluids were not transported from the manufacturers.
- The diagnostic imaging unit was located adjacent to the minor injuries unit (MIU). This allowed easy access for patients from the MIU. The department accepted referrals from local nursing homes to prevent frail older people having to travel to other trust sites. Radiology staff would work late to see patients who arrived at the minor injuries unit towards the end of the shift who required an x ray.
- The x-ray equipment produced high quality images that were available to staff in five minutes and one of the radiographers was a reporting radiographer and could produce a diagnostic report. This meant that patients received a prompt diagnosis of their condition and could be treated in timely manner. It also reduced the number of times that a patient needed to attend the hospital.
- Due to consultant vacancies and increasing numbers of referrals for imaging the trust were outsourcing some of their reporting. At Trafford and Altrincham the

percentage of plain imaging outsourced was 70% in September 2015 and 94% in August 2015. In comparison the rest of the trust outsourced 14% of their plain imaging in September 2015 and 13% in August 2015. This meant that there were additional costs for the trust but staff could be released to do the more complex MR and CT reporting.

**Access and flow**

- Patients use choose and book system which allows patients choice when booking OPD appointments.
- In the period April 2015-September 2015 93.6% of patients at Trafford and Altrincham had started non-admitted treatment (out-patient appointments) within 18 weeks of referral. This was worse than the NHS operational standard of 95%.
- The failure to attend rates for new patient appointments at Altrincham were 6.9%. This was better than the England average of 8.8%
- The percentage of people waiting over six weeks for a diagnostic test at Trafford and Altrincham was 0.8%. This was better than the England average.
- The phlebotomy clinic at Altrincham was very busy. There was a treatment area with space for four staff. If there was full staffing patients were not waiting long but if not fully staffed patients were waiting up to two hours for a blood test. We spoke to staff and patients who confirmed this.
- The service ran from 8.00am-3.30 pm, though the service became busy early. This was because some patients required fasting blood tests and others were on their way to work. Managers were aware of the problems and another two staff had been employed to rotate between the Altrincham site and the Trafford site. They were also considering evening clinics and Saturday clinics.
- The transport to the laboratory for blood samples left Altrincham at 4pm, if the service was running late; samples had to be sent by taxi.
- On the renal unit patients attended on alternate days Monday –Saturday. The first cohort of patients attended early in the morning with the next cohort of patients arriving at 11am.The dialysis treatment lasted about four hours. This meant that 40 patients were seen every day. Space could be found if patients had missed their appointments as there were spare dialysis machines.

**Meeting people's individual needs**

- Some qualified staff in OPD had undertaken some training in breaking bad news to patients.
- In OPD if a referral was made for a patient with a learning disability or autism a pre visit was arranged. This meant that patients were reassured about their treatment A double appointment was booked and the patient would be first on the days list. On arrival they would wait in the clinic room. Transport was organised if necessary. Some procedures had pathways that were in picture format for patients and easy read information was available.
- Health watch had commented on the signage at the hospital. This had been replaced by large print floor numbers for visibly impaired people**.**
- Following attendance at an OPD clinic a letter was sent to the patient's GP within two weeks.
- In the OPD, some patients had reported that they could not hear when their names were called out. Staff had responded by going round the clinic calling people's names.
- We saw that translation services were available. The trust website information was available in over 90 languages.
- All patients at the renal dialysis unit had a named nurse. Where a patient required one to one support; this was provided by a member of staff during their treatment.
- Patients could access a system that allowed them to view their blood test results from home.
- There was a shared care service for dialysis. Some patients did not have space in their homes for the dialysis equipment and could use the machines in the hospital. Other patients needed some support from staff to be able to dialyse themselves. There was a separate unit with nine beds where patients had ten days training and a competency assessment before they were given a machine to dialyse at home. There were six patients who acted as advisors for those considering this training who were available to speak to patients.
- Patients attending for dialysis who were on the kidney transplant list were tissue typed monthly in the event of a kidney becoming available for transplant.
- The ward clerk on the renal had weekly meetings with patient transport services to address any problems with patients who needed these services. If there were delays in transport the unit could offer refreshments as many of the patients had diabetes.

# Outpatients and diagnostic imaging

- We spoke to two patients who were waiting for x rays. They had been seen promptly at the minor injuries unit and were happy with the service provided. They said that they were glad they could be seen locally.

**Learning from complaints and concerns**

- Complaints were handled in line with trust policy and were resolved locally whenever possible; if not patients were directed to the Patient Advice and Liaison service (PALS) and then to the formal complaint system. PALS leaflets were available throughout all departments.
- Complaints were usually about communication and appointment cancellations. These were discussed at the monthly clinical effectiveness meetings and action plans were developed for each complaint.
- Feedback about the phlebotomy clinic was being addressed by the trust as were other issues including parking and the lack of refreshments available at the hospital.

## Are outpatient and diagnostic imaging services well-led?

Good

We rated outpatient and diagnostic imaging services as 'good' for well-led because;

There was a matron for outpatients who covered both Trafford/Altrincham sites; they reported to the clinical manager of out-patient medical services for Trafford/ Altrincham. The divisional management board for Trafford/ Altrincham reported directly to the trust management board.

Staff felt supported by their local managers who were visible in the hospitals. Leadership was responsive to the needs of patients. The staff worked together as a team and supported each other when the services were under pressure from increasing demand.

The development of the outpatient standards and the baseline assessment had focused staff and managers to look at the positive and negative aspects of the service. Staff knew what they needed to do to improve their service and were committed to achieving improved services for patients.

Leadership on the renal ward was effective, staff worked well as a team to deliver the best outcomes for patients.

The diagnostic imaging department were developing new roles for their staff to improve services for patients.

**Vision and strategy for this service**

- The development of the outpatient standards and the baseline assessment of the service had driven service development for outpatient services. Managers and staff knew what they needed to do to improve services and had developed plans for specific service areas.
- Staff knew about the vision for their hospital but were not fully engaged in the vision of the wider trust.
- There was a clinical radiology five year strategic plan for the trust, this included role extensions for radiographers to address some of the current issues about recruitment and retention of staff in the diagnostic imaging service.

**Governance, risk management and quality measurement**

- The outpatient standards were monitored for compliance by the quality committee. This was one of a number of committees that fed into the divisional clinical effectiveness committee; the other committees included audit and quality. These then fed into the divisional management board at Trafford. Monthly divisional clinical governance meetings were held for the Trafford hospitals.
- Self-assessments against the standards were to be done twice a year and quality reviews were to be done every year but had not yet been started.
- There was a risk register for out-patients and diagnostic imaging across the trust with review dates.
- There was a radiology clinical effectiveness group across the trust.

**Leadership of service**

- The local Trafford hospitals leadership was effective and visible at the Hospital sites. The trust board and executive team were not as visible.
- Clinical leadership across both sites was responsive and cohesive; divisional managers were visible in the trust and were respected by staff.
- There was a new nurse manager for both sites to start in December 2015.

- Staff at the renal dialysis unit said their manager was excellent and supported them to be the best they could be.

**Culture within the service**

- There was a positive culture across the departments of the hospital. This had changed over the last few years, which were described by the staff as difficult. Staff said the merger of Trafford hospitals with the Central Manchester Foundation trust (CMFT) in 2012 had not been easy.
- The move to the new hospital site had also been a challenge but all appreciated the new hospital environment.
- There was more staff rotation across the trust and more integrated working.
- Staff described the hospital as a small and friendly place to work; many staff were from the local community.
- Staff at the renal dialysis unit said that the hospital was an excellent place to work and that team working was good and described their work as very rewarding. They also said that they felt corporately more embedded into the trust since their recent move from Wythenshawe hospital; the move had gone smoothly and staff liked the new surroundings. They said they were now an out-patient service for their patients.

**Public engagement**

- There were patient trackers around the hospital where patients could feed back about their experiences. The patient tracker information and patient experience surveys were used in the development of the outpatient standards.
- There were expert patient groups in orthopaedics and diabetes and a patient led group had written an audiology leaflet.
- The trust worked with health watch and a patient experience report was produced in August 2015 and updated in October 2015. The positive experiences were the friendly, helpful staff, good service in the minor injuries unit and ENT and phlebotomy. The negative comments were about the phlebotomy service, waiting times and accessible parking. Signage had also been improved directing people to different departments following feedback from Healthwatch.

**Staff engagement**

- The development of the outpatient standards had involved engagement with staff using various methods.
- Staff said that communication was much improved and that they get answers about their concerns.
- There was a wellness day for staff and patients which was well received.

**Innovation, improvement and sustainability**

- The development of the out-patient standards across the trust was improving the service. The baseline assessment of service areas had identified positive and negative issues; action plans had then been developed. The continuous self- assessments and quality reviews would ensure that improvement continued and that improvements were sustainable for the future.
- The use of reporting radiographers on the Trafford/ Altrincham sites provided a rapid reporting service 9.00am -5pm Monday – Friday. X-rays for patients attending A&E or the minor injuries unit were reported in in a timely fashion that facilitated diagnosis and discharge.
- The production of dialysate fluid for renal patients on site to reduce costs and the carbon footprint of the unit was seen as innovative practise.
- The training programme and competency assessment for patients who want to dialyse at home supported by renal patients giving advice and support again was innovative and well received by patients and their families.

# Outstanding practice and areas for improvement

## Outstanding practice

- The staff approach to patient care and commitment to providing compassionate care to patients.
- The use of reporting radiographers on the Trafford/ Altrincham sites provided a rapid reporting service 9.00am -5pm Monday – Friday. X-rays for patients attending A and E or the minor injuries unit were reported in in a timely fashion that facilitated diagnosis and discharge.
- The production of dialysate fluid for renal patients on site to reduce costs and the carbon footprint of the unit.
- The training programme and competency assessment for patients who want to dialyse at home. This was supported by renal patients giving advice and support.

## Areas for improvement

**Action the hospital SHOULD take to improve**

**In Minor Injury services:**

- The trust should ensure that all oral medications are clearly labelled with an opened date recorded clearly on the bottle.
- The trust should ensure that the temperatures of the fridges used to store medication are recorded daily.

**In outpatients and diagnostic imaging services:**

- The trust should reduce their waiting times for phlebotomy services at Altrincham hospital
- The trust should consider upgrading the tympanometers in audiology OPD as the equipment is outdated and giving inaccurate results which could affect patient outcomes.
- The trust should look at different ways of working to address the recruitment and retention of radiologists and radiographers.