University Hospital of South Manchester NHS Foundation Trust

Wythenshawe Hospital

Quality Report

Wythenshawe Hospital
Southmoor Road
Manchester
Greater Manchester
M23 9LT
Tel:01619987070
Website: www.uhsm.nhs.uk/

Date of inspection visit: 26 to 29 January 2016
Date of publication: 30/06/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Wythenshawe Hospital is one of two locations providing care as part of University Hospital of South Manchester NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

We carried out an announced inspection of Wythenshawe Hospital on 26-29 January 2016 as part of our comprehensive inspection of University Hospitals of South Manchester NHS Foundation Trust.

Overall, we rated Wythenshawe Hospital as 'Requires Improvement'. However, we rated the service as good for children and young people services, end of life and critical care. We found that services were provided by dedicated, caring staff and patients were treated with dignity and respect. However, improvements were needed to ensure that services were safe and responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- Overall, patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- Across medical services nurse staffing levels were variable. There were vacant posts on all wards that were being filled by either staff working extra hours, or bank and agency workers. Staffing had been identified as a risk on the divisional risk register and all staff highlighted this as an area of concern. Actions had been identified to mitigate the risk.
- The neonatal unit did not consistently meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). Additionally, nurse staffing levels on starlight ward did not reflect Royal College of Nursing (RCN) standards; an acuity tool on the starlight ward was not in use at the time of the inspection.
- There were four vacancies in paediatric nurse staffing within the emergency department at the time of the inspection but recruitment was in progress.
- Within the diagnostic and imaging department there were challenges with regard to recruitment and retention of nurses and radiographers within the diagnostic and imaging department.

Medical staffing

- There was a reliance on locums within the emergency department to fill 28% of medical shifts. There were four vacancies in paediatric nurse staffing within the department but recruitment was in progress.
- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care.

Summary of findings

Leadership and Management

- The senior team, in the majority of core services, were visible and accessible and well known to the staff.
- There was a lack of engagement and leadership from senior clinicians within the maternity services. This lack of engagement had resulted in a significant delay in investigating incidents and reviewing and updating clinical guidance.
- Within children and young people's service the local leaders on the ward and units were visible and managers were actively involved in the day to day running of the paediatric areas. However we noted that managers undertook clinical duties to increase staffing numbers which consequently meant they had limited time for managerial duties.

Access and Flow

- Access and flow was identified as a concern in the emergency department. The ED had not met the target to see, treat, admit or discharge patients within four hours at all in the last 12 months. Initiatives were in place to try to address this.
- Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services. Between January 2015 and December 2015, bed occupancy rates across medical services were over 100%, ranging from 101% to 104%. Due to the shortage of beds in medical services, patients were being treated on wards not best suited to their needs (also known as outliers). The trust ensured that all outliers were seen by a consultant, and each ward had a named consultant to carry out this role on a daily basis.
- There were challenges with access and flow through surgical services; however services were responsive to individual needs of patients. We observed numerous examples where staff adapted services to the needs of patients, including delivering medication through sign language to a deaf patient. The trust had considered the changing needs of its population and had trained staff to be ward leaders in care for people with dementia.
- Within critical care there was insufficient capacity to meet patient need which meant patients were not always admitted promptly to receive the right level of care. The high bed occupancy levels in the critical care services meant operations were cancelled due to the lack of available critical care beds.
- As part of the trust's escalation policy, patients were transferred to the main 'theatres recovery area when there were no critical care beds available. There had been 59 occurrences of patients being nursed overnight in theatre recovery from April 2015 to October 2015. Patients kept overnight in recovery were assessed by critical care consultants. However, they were cared for by recovery nurses that had not completed all the relevant competencies to treat critically ill patients. There were plans in place to provide training for recovery staff by the end of March 2016.
- Patients were not always discharged from critical care in a timely manner due a lack of available ward beds and capacity constraints across the trust. ICNARC data up to September 2015 showed the number of reported delayed discharges (within and greater than four hours) was worse than other comparable units nationally. The data showed the delayed discharges were consistently 10% to 20% above the average since January 2013.
- The smooth flow of patients on ward F16 was interrupted by limited access to sonography. The shortage of scanning sessions available in the early pregnancy assessment unit led to unnecessary admissions to the ward.
- Diagnostic waiting times were worse than the England average from August 2014 onwards, with performance particularly poor during the second half of 2014. Between June 2015 and September 2015 the proportion of radiological investigations reported on within 10 days ranged from 68% to 75.5%. The did not attend (DNA) rate at Wythenshawe Hospital was higher than the England average each month since February 2015.

Summary of findings

We saw several areas of outstanding practice including:

- The bereavement midwife had been nominated for the national Butterfly awards two years running. These are awards celebrating survivors and champions of baby loss. The bereavement midwife was also runner up in the Royal College of Midwifery awards for her work providing bereavement support.
- A rapid access clinic had been introduced for menstrual disorders and post-menopausal bleeding to meet demand and allow for the development of innovative out-patient treatments such microwave endometrial ablation and hysteroscopy sterilisation.
- The cystic fibrosis team were awarded the quality improvement award by UK cystic fibrosis registry annual meeting in July 2015. The paediatric CF team won the first National Cystic Fibrosis Registry Quality Improvement Award in recognition for innovative use of the Port CF database, which provided focussed and early intervention to prevent further deterioration in their patient's condition.

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

Importantly, the trust must:

In Urgent and Emergency Care:

- Ensure equipment checks in resuscitation areas are completed daily in line with trust requirements with a clear pathway for reporting associated concerns and actions such as missing equipment and subsequent replacement.
- Ensure staff appraisal rates consistently meet the trust target.
- Ensure the safety of reception staff at all times and take steps to mitigate current risks associated with the reception environment such as no protective screens and open desk areas.
- Ensure that the temperatures of fridges storing medicines at low temperature, are recorded in line with guidance on a daily basis, and that required issues are consistently reported.
- Ensure action is taken to remove the risk of ligature from ceiling vents in the mental health room, in line with guidance from the Royal College of Emergency Medicine (CEM6883 Mental Health in EDs toolkit February 2013)
- Consistently improve patient waiting times in line with Department of Health targets.

In Medicine:

- The trust must ensure that staffing levels are appropriate to meet the needs of patients across the medical services and ensure there is an appropriate skill mix on each shift.
- The trust must ensure that all records are stored securely when not in use.
- The trust must take action to improve the bed occupancy rates across medical services to ensure the safe care and treatment of patients.

In Maternity:

- The trust must improve mandatory training for midwifery staff in terms of safeguarding level three training to ensure it is in line with the trust target.
- The trust must ensure all clinical policies are regularly reviewed and kept up to date.
- The trust must ensure incidents are investigated in a timely manner to ensure lessons are learned and recommendations implemented.

In Children and Young People:

- The service must ensure safe staffing levels are sustained in accordance with National professional standards and guidance.

Summary of findings

- The service must ensure that staff are reporting risks and incidents to the senior leaders of the service actions being taken in a timely manner.
- The service must ensure that all treatment, assessments, diagnostics and any other care relating to the patient is recorded appropriately in patient records.
- Ensure that transition arrangements for children between 16 and 18 years meet the needs of the individuals without prejudice.

In addition the trust should:

In Emergency Department:

- Review the security of the paediatric ED entrance to ensure children are safe at all times
- Introduce recording of completed cleaning to ensure contemporaneous records are available
- Improve the cleanliness of areas found to have dust and debris on the floor (store room and mental health room)
- Review the storage of equipment in open packaging, or without packaging in the resuscitation area.
- Improve the uptake of mandatory training for medical and nursing staff where there are pockets of low compliance.
- Reduce locum usage in the ED whilst maintaining appropriate staffing levels.
- Improve service for patients and relatives in relation to food and refreshments in the ED.
- Put appropriate actions in place to improve services following local or national audit and ensure that relevant staff are aware of findings.
- Review the role of the discharge lounge in ensuring access and flow through the ED.

In Medicine:

- The trust should take action to ensure that all necessary patient risk assessments are completed across medical services in accordance with the National Institute for Health Care Excellence (NICE) guidance.
- The trust should ensure that all ligature risks are identified and risks mitigated to ensure patients at risk of harming themselves are protected.
- The trust should ensure that patients are discharged as soon as they are medically fit.
- The trust should ensure that patients are not moved ward more than necessary during their admission and are cared for on a ward suited to their needs.
- The trust should take action to ensure that all staff receive annual appraisals.
- The trust should take action to provide the necessary mandatory training for medical staff.
- The trust should cascade major incident planning information to all staff across medical services.

In Surgery:

- The provider should ensure that there are adequate numbers of suitably qualified staff to ensure safe patient care and maintain a safe environment.
- The provider should ensure that it develops a recovery plan to address the bed capacity difficulties that surgical services are experiencing, in order to resolve the high number of late cancelled surgical procedures and improve referral to treatment times.
- The provider should ensure that any difficulties with clinical leadership, including nursing and medical leaders, should be fully resolved in order that all surgical services should be well-led.

In Critical Care:

Summary of findings

- Take appropriate actions to reduce the number of delayed discharges.
- Take actions to ensure patients kept in theatre recovery receive appropriate care and treatment.

In Maternity:

- Consider the number of scans available to prevent women having to be admitted to the ward or to the emergency department after 18:00.
- Improve the uptake of mandatory training for medical and nursing staff.
- Review all guidance and ensure it is in date and fit for purpose.
- Review the number of sonography sessions available in the early pregnancy unit to prevent unnecessary admissions to the ward.
- Staff should receive feedback from incidents.
- Review midwifery staffing levels to reach trust targets with midwifery staffing ratios.

In Children and Young People:

- The service should consider how sufficient time for the ward manager to perform managerial tasks associated with the role can be supported.
- The service should consider protecting nurse training time to develop staff.
- The service should consider improving their CAHMS pathway.
- The service should consider training on incident reporting with emphasis on informing staff what the trust constitutes as an incident.

In End of Life:

- The trust should ensure that all staff groups have access and are trained to use the trusts electronic reporting system.
- The trust should consider requesting feedback about the quality of mortuary services from partner agencies such as funeral directors.
- The trust should consider developing a work schedule in relation to narrowing the gap between preferences and place of death.
- The trust should set targets for completing all action plans.
- The trust should consider making testing major incident plans.
- The trust should consider ensuring audits reach the appropriate target audience so that senior clinicians are able to comment on their area of responsibility such as use of the individual plan of care booklet.
- The provider should ensure all doctors who sign DNACPR include their position and GMC number as requested on the form.
- The trust should ensure the leadership structure for all services involved in palliative and end of life care is clearly defined.
- The trust should consider completing a staff survey to enable staff to comment on the quality of the service and future developments.

Summary of findings

- The trust should consider making the use of the most effective end of life care planning tool mandatory or develop a policy and risk assessment which supports two systems currently in use.
- The trust should review the medication policy to ensure management of prescription forms in the community is in line with best practice guidance.
- The trust should ensure the pain scoring assessment tool is used in conjunction with the pain plan of care.

In Outpatients and Diagnostic Imaging:

- The trust should take action to ensure that equipment is available and fit for use with minimal disruption to the service.
- The trust should ensure a record is maintained of the minimum and maximum of fridge temperatures for each medication fridge.
- The trust should take action to address the issue of x-ray requests being completed using the log in of another referrer.
- The trust should put measures in place to allow patients to book in to outpatient and diagnostic areas without being overheard.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We have given Urgent and Emergency care services at Wythenshawe Hospital an overall rating of requires improvement. There was a culture of reporting and sharing learning openly and honestly. The department was visibly clean and tidy in all but two rooms. Cleaning staff were present on a daily basis and the trust monitored cleanliness and infection prevention and control. The ED infrastructure was fit for purpose and staff thought innovatively to ensure space was used. Medicines were organised and within expiry date with appropriate checks in place to ensure proper use. Records were stored securely and contained comprehensive details about patients. The trust had a central safeguarding team and safeguarding link nurses with specialist knowledge worked in the ED. However, not enough staff were up to date with safeguarding training and compliance with other mandatory training was also low in most staff. Staff managed patient risk using a rapid assessment and treatment model and a triage system. Some treatments were instigated during initial assessment. Staffing was adequate and vacancies were handled through recruitment and agency or locum staff. However, trust records showed reliance on locums to fill 28% of medical shifts. There were four vacancies in paediatric nurse staffing but recruitment was in progress. Major incident equipment was fit for purpose and regularly checked. Equipment was stored in an organised way, within expiry date. Checklists helped ensure equipment was available in treatment areas. However, there was no standardised process to confirm missing equipment had been replaced. Staff used national and local guidelines and pathways to provide care. Food and refreshment

Summary of findings

was available but not always offered to patients and visitors. Local and national audits were undertaken. Patients were assessed for pain and treatment was provided when appropriate.
New staff followed an induction process. Appraisal rates were considerably lower than the trust target of 85%.
Staff from different disciplines worked together to provide services for patients. We saw evidence that patient consent was obtained. Mental health staff provided assessments and staff understood the principles of the Mental Health Act 2005.
Although the main ED was open 24 hours a day seven days a week, 365 days a year, not all services operated at evenings or weekends.
Staff were friendly, helpful and respectful, introducing themselves to patients who said they felt informed about their care.
There were systems in place to identify patients who had passed away provide specialist support for bereaved relatives or loved ones.
Language interpretation, sign language and multi faith rooms were available. Link nurses provided specialist knowledge in areas such as dementia, alcohol misuse and safeguarding. Information leaflets were available for patients.
Access and flow remained a problem. The ED had not met the target to see, treat, admit or discharge patients within four hours at all in the last 12 months. Initiatives were in place to try to address this.
We saw evidence that formal complaints were investigated and action taken to resolve them and limit recurrence.
There was a strategy in place for the future and staff were aware of plans to expand the ED over the next three years.
Governance, risk and quality was measured and recorded appropriately, and discussed on a monthly basis in formal meetings. The department had a risk register with risk ratings, actions to mitigate risk, and review dates.
Staff felt well supported by leaders and described a positive team culture with good staff engagement.
Staff thought innovatively about improving access and flow and the department itself through accreditation schemes.

Summary of findings

Medical care (including older people's care)

Requires improvement

We found concerns in relation to safety due to nurse staffing numbers, the storage of records, the completion of risk assessments, and responsiveness of the service due to bed occupancy.

Nurse staffing levels across the medical wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours, or bank and agency workers. Staff were regularly moved to cover other wards leaving their own ward short of staff. All staff we spoke with reported concerns about staffing levels across medical services. All managers reported staffing levels to be a risk and it was on the divisional risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment and rotas planned well in advance by ward managers and using health care staff to increase the amount of staff on the wards. However, this could potentially lead to a risk of an imbalance of skill mix, and did not mitigate the need for trained nurses to be on shift to provide the care and treatment required.

There were ligature risks in patient bathroom facilities. At the time of inspection these risks were not assessed in order to protect patients who were at risk of harming themselves.

Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services. Between January 2015 and December 2015, bed occupancy rates across medical services were over 100%, ranging from 101% to 104%. This meant that there were more patients needing medical beds than they actually available. Due to the shortage of beds in medical services, patients were being treated on wards not best suited to their needs (also known as outliers). The trust ensured that all outliers were seen by a consultant, and each ward had a named consultant to carry out this role on a daily basis.

The service used national guidelines and evidence based practice in providing treatment and developing pathways and audits. Audits were completed on both a local and national basis. There were action plans in place to drive improvement, where needed. However, not all risk assessments had been completed in line with the National

Summary of findings

Institute for Health and Care Excellence (NICE) guidance. Data provided by the trust showed that not all medical wards had met the trust target in compliance with completing Venous Thromboembolism (VTE) assessments throughout 2015.

Records were completed appropriately and we were able to follow and track patient care and treatment easily. However, not all records were kept in locked trolleys or in a locked room to ensure confidentiality.

Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as moving and handling, fire safety, conflict resolution and dementia awareness. At the time of our inspection the trust reported 89% of medical services staff had completed their mandatory training. However, mandatory training was not up to date for all doctors across medical wards.

Major incident planning took place, however we found that plans had not cascaded down to staff across medical wards. Incidents were well reported by staff, and they had a system in place to safeguard vulnerable people. Medicines were stored and handled appropriately, and regularly checked to ensure compliance with medicine safety.

The wards we visited were visibly clean, and regular auditing took place to ensure the environment was clean and safe for patients. Infection rates were monitored and displayed on all wards we visited.

Patients spoke positively about their care and treatment. They were treated with dignity and respect. Data for patient satisfaction surveys showed most patients were positive about recommending the department to friends and family. Patients and those close to them were supported with their emotional needs.

There was a focus on discharge planning for patients on all wards we visited. Staff discussed discharges at daily board rounds and bed management meetings. The board rounds provided staff with an overview of the care and treatment for each patient and arrangements required to safely discharge a patient. Once patients were discharged, discharge summaries were provided to patients and sent to their general practitioner.

Summary of findings

The senior team were visible and accessible and well known to the staff. Staff felt the managers were approachable and supportive.

Surgery **Requires improvement**

Staffing levels across surgical services were good, but there was one ward where there were periods of understaffing, which were not always able to be addressed quickly. The trust had previously recognised that staffing levels on two wards were too low to be safe at full capacity. The low levels of staffing had been observed to have an impact on patient care, in that these wards had reported high numbers of incidents, one for falls and the second for pressure ulcers.

In response to the difficulties on these wards trust management had taken appropriate action. This situation had detrimental impact on capacity within surgical beds, which further aggravated trust wide capacity issues and contributed to the high numbers of cancelled operations and failure to meet referral to treatment times.

From December 2015 these wards received substantial extra support and development, which was reflected in the improvements that we found on inspection. We noted that the ward where the incidence of falls had previously been high, had witnessed a reduction in falls, as a result of the measures that had been put in place. Although the second ward had not witnessed a reduction in pressure ulcers, morale had improved and ward based training sessions were being delivered by clinical leaders. However, when we visited this ward on three occasions, there were low staffing numbers for the dependency of the patients, the ward was chaotic, ward equipment was in front of emergency equipment and call bells were being left unanswered for significant periods of time.

There was a positive culture of incident reporting, with staff understanding the value of reporting incidents in improving patient safety. There was a low incidence of infection on all wards across surgical services. Apart from the two wards mentioned, all wards had safe staffing levels with a skill mix deemed appropriate for patient acuity and dependency levels. Medical records were fully completed and medicines were managed safely.

Summary of findings

Surgical services provided effective services to patients. It provided services in line with national guidelines and implemented local policies based on national guidelines. Patient's pain was assessed both pre-operatively and when they arrived on the ward. This pain score was documented and pain relief was administered in a timely fashion. If ward staff required more support when dealing with a patient's pain, they were able to access the trust pain team. There were good relationships between the pain team and surgical wards, with the pain team visiting some wards on a daily basis.

We observed that surgical services were caring towards patients, interacting with patients in a kind and respectful way. We were able to speak to a number of patients and relatives who stated that all staff were caring and involved them in discussions and decisions about their care.

There were some challenges with access and flow through surgical services; however services were responsive to individual needs of patients. We observed numerous examples where staff adapted services to the needs of patients, including delivering medication through sign language to a deaf patient. The service had considered the changing needs of its population and had trained staff to be ward leaders in care for people with dementia.

The management of surgical services was focused on patient safety and ensuring high standards of care and treatment were provided to patients. Managers and clinical leaders were aware of the issues facing services, such as the ward staffing difficulties and the problems with access and flow through surgical services. They had addressed these problems and developed plans to reduce them. However, at the time of inspection the problems were still evident and impacting on patient care. Managers were not fully aware, however, of the reasons why care had not improved on a ward with difficulties. They had not fully identified the extent to which difficulties with clinical leadership continued to impact on patient care and limit the improvement in care.

Staff morale across surgical services was, in most cases, very high across all professional groups. Directorate medical directors were focused on new

Summary of findings

Manchester wide initiatives. Trust management was visible and staff spoke very highly of senior nursing leaders, believing them to be approachable and interested in ward staff.

Critical care

Good

We gave the critical care services at Wythenshawe hospital an overall rating of good. However, we found further improvements were needed in relation to how the service responded to patient needs.

This was because there was insufficient capacity within the critical care services which meant patients were not always admitted promptly to receive the right level of care. The high bed occupancy levels in the critical care services meant operations were cancelled due to the lack of available critical care beds.

As part of the trust's escalation policy, patients were transferred to the main 'theatres recovery area when there were no critical care beds available. There had been 59 occurrences of patients being nursed overnight in theatre recovery from April 2015 to October 2015. Patients kept overnight in recovery were assessed by critical care consultants. However, they were cared for by recovery nurses that had not completed all the relevant competencies to treat critically ill patients. There were plans in place to provide training for recovery staff by the end of March 2016.

Patients were not always discharged from critical care in a timely manner due a lack of available ward beds and capacity constraints across the trust. ICNARC data up to September 2015 showed the number of reported delayed discharges (within and greater than four hours) was worse than other comparable units nationally. The data showed the delayed discharges were consistently 10% to 20% above the average since January 2013.

The critical care services had implemented a new patient flow policy in December 2015 to improve access to critical care and reduce delayed discharges. There was also a plan to open a two-bedded long term ventilation and weaning unit by July 2016 that was expected to free up capacity and improve patient access to the adult intensive care unit (AICU).

Summary of findings

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises and were supported with the right equipment. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating.
Patients were supported by trained, competent staff. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. Patients and their relatives spoke positively about the care and treatment provided. They were treated with dignity, empathy and compassion and supported with their emotional and spiritual needs.
The services provided care and treatment that followed national clinical guidelines and performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit. There was effective teamwork and clearly visible leadership within the critical care services and staff were positive about the culture and level of support they received. Key risks to the services, audit findings and quality and performance was monitored though routine departmental and clinical governance meetings.

Maternity and gynaecology **Requires improvement**

There had been a backlog of incidents requiring investigation and a lack of clinical engagement in the investigation process. At the time of our inspection, the service was receiving reports from the investigation of incidents that had occurred 20 months ago. This meant that there was a significant delay in the service understanding and sharing the learning arising from these incidents and a delay in making improvements to enhance the safety of the service as a result. We found a lack of incident reporting and a downward trend in number of incidents reported in a 12 month period.
There had been a long standing concern within maternity services in terms of safeguarding children's level three training. At the time of the inspection compliance for the service was below the trust target.
Mandatory training compliance was slightly worse than the trust target for maternity services.

Summary of findings

Concerns were raised in terms of the senior medical rota on delivery suite. Staff felt that the management of patient risk was fragmented and there was little continuity of care due to the rota being split into four separate shifts. We were informed this could lead to care plans changing more frequently and clinicians delaying making a decision until the next doctor took over.
The ratio of midwives to births within the service at the time of our visit was one midwife to every 31 births, which was worse than the England average and trust target. The service had not been compliant with this target since February 2015.
The smooth flow of patients on ward F16 was interrupted by limited access to sonography. The shortage of scanning sessions available in the early pregnancy assessment unit led to unnecessary admissions to the ward.
There was a lack of engagement and leadership from senior clinicians within the service. This lack of engagement had resulted in a significant delay in investigating incidents and reviewing and updating clinical guidance.
A review of the services and of medical staffing in June 2015, conducted by the new Clinical Director concluded 'ineffective clinical leadership had resulted in a fragmented disorganised service with wide variation in practice, with no cohesion between the senior clinicians and no significant professional development or succession planning'.
The unit governance information and incident update had not been distributed since June 2015 and there was no group for reviewing and updating clinical guidelines. We subsequently saw no evidence of lessons learned being shared with staff.

Services for children and young people

Good

Overall we rated children's and young people's service as good.
Staff were competent in their roles. Mandatory training, including safeguarding, was above the trust targets.
Multidisciplinary and departmental meetings were held amongst all areas of the service. Meetings were regular and were used to explore ideas to improve the patient pathway. They were well attended by senior clinicians and ward managers, safeguarding and other teams. The service was proud of their

Summary of findings

togetherness and gave several examples where service had improved following these meetings. For example to ensure there were enough beds for patients who presented at the paediatric emergency department (PED), the paediatric day case unit offered staffing support to the paediatric assessment and observation unit. This improved the access and flow pressures in the PED.

The local leaders on the ward and units were visible and managers were actively involved in the day to day running of the paediatric areas. However we noted that managers undertook clinical duties to increase staffing numbers which consequently meant they had limited time for managerial duties.

Staff were motivated in their roles and worked well together to deliver a quality and efficient service. There was a strong focus on delivering safe patient care and managers supported staff to develop their skills. However, staff were not always able to attend workshops or training sessions because of operational pressures and time was limited. The service lacked direction and support from the executive board level; this was evident from the staffing provisions.

The neonatal unit did not always meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). Nurse staffing levels on starlight ward did not reflect Royal College of Nursing (RCN) standards; an acuity tool on the starlight ward was not in use at the time of the inspection. We raised concerns with senior leaders, highlighting the need for more staffing provisions in both areas. Staff undertook extra shifts on a weekly basis to make the ward safe but this was not sustainable. It was evident that staff were overworked but many staff felt obligated to pick up more than three extra shifts to make sure the ward ran efficiently so that care was delivered safely. The percentage of consultants (26%) working in paediatrics was worse than the England average (35%). Staff felt there was a lack of senior leadership. Although staff were aware of how to escalate their concerns to their manager or matron at ward level, there was little evidence of direction or support to mitigate risks from the executive board because staffing levels had not been addressed.

Summary of findings

Documentation on the paediatric ward was poor. We also raised concerns about the transfer of nursing notes from the nurse led book. This book contained patient information and was used by nursing staff as a daily task list. After cross referencing the book with 16 medical and nursing case notes we found 10 patients notes did not contain information that had been written in the nurse-led book. These concerns were escalated to the executive team on the unannounced inspection The nurse led book also raised serious concerns about data protection; If the nurse led book was requested by a parent this would also contain information about other children. This information was not coded and was not redacted once the book was completed.
Transition arrangements for children between 16 and 18 years were found to be rigid with all children over 16 years admitted to the adult services. This included children and young people admitted with mental health or self-harm concerns and also included young people with learning disabilities. The adult service used the integrated care pathway and escalated risk pathway however this pathway had been designed for adult patients.

End of life care

Good

Overall we rated end of life care as good because:
The trust responded to practice changes in relation to replacing the Liverpool Care Pathway and in June 2014 introduced the 'Individual plan of care for people who are dying' (IPoC). This was based on 'Five priorities for end of life care' developed by the Leadership Alliance for the Care of Dying People.
The specialist palliative care team and other services involved in end of life care were caring and took steps to maintain patient dignity and comfort. Processes were in place to provide emotional and practical support to the patient and their family. There was provision for people with communication difficulties, this included an interpreter service. Multiagency working was well established and processes were in place to enable patients and relatives to be involved in advance care planning. Preferences were observed when possible and cultural and religious needs were taken into account.

Summary of findings

The trust provided a seven day a week specialist palliative care service in the hospital. Due to staff shortages and uncertain funding arrangements, the community team had been reduced to five days.
The trust provided an out of hours on-call service to the hospital staff and district nurses and GPs.
Processes were in place to ensure senior doctors were able to assess the patient's needs using the five priorities. Medications to control the symptoms of end of life (anticipatory medication) were prescribed in good time.
Areas for improvement were identified in relation to prescribing medication and assessing pain. The medication administration record did not differentiate between whether medication was been given for pain control or to relieve shortness of breath. This meant that medication record could not be interpreted without referring to the medical or nursing notes. Also, although an initial pain assessment was completed and medication prescribed, staff did not routinely score the level of pain described by the patient using the tool provided. This meant the effectiveness of pain control was not monitored in line with best practice guidance.
The trust participated in a number of local, regional and national audits and re-audits to identify areas of effective practice and improvement. They were proactive in developing and implementing action plans to improve adherence to best practice guidance or develop new ways of working. This included monitoring whether end of life care was consistently delivered against the 'five priorities of the dying person', preferred place of death and access to palliative care services. Audits, plans and checks could be improved if targets dates for the completion of projects were always identified.
Do not attempt cardio-pulmonary resuscitation documentation was consistently completed to a good standard. Staff understood the systems in place for escalating safeguarding concerns and demonstrated a good understanding of the Mental Capacity Act.
Nurse managers and senior medical staff who led services involved in end of life care in the trust were

Summary of findings

accessible to staff, patients and their relatives. The trust's 2010 -2020 strategy for end of life care was in draft stage and should be expedited, however, strategic work to improve services were ongoing. The trust had introduced customer satisfaction processes and acted on information provided by patients, relatives and staff. The trust should consider a staff survey aimed at palliative care and end of life staff.

We visited 13 wards, the multi-faith centre, the chaplaincy service, the chapel of rest, the mortuary and the bereavement office. We spoke with nine patients and relatives. We also talked with 52 members of staff from all departments at the trust involved with providing with end of life and palliative care services. We reviewed the trust's performance data.

Outpatients and diagnostic imaging — **Requires improvement**

The trust experienced a shortage of nurses and radiographers within the diagnostic and imaging department. Ageing equipment within radiology had begun to impact on service delivery. Diagnostic waiting times were worse than the England average from August 2014 onwards, with performance particularly bad during the second half of 2014. Between June 2015 and September 2015, the proportion of radiological investigations reported on within 10 days ranged from 68% to 75.5%. Some patients with increased body mass index (BMI) could not receive the gold standard diagnostic procedures for breast problems due to doorways not being wide enough in the Nightingale Centre.

Wythenshawe Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Wythenshawe Hospital	22
Our inspection team	23
How we carried out this inspection	23
Facts and data about Wythenshawe Hospital	24
Our ratings for this hospital	24
Findings by main service	26
Action we have told the provider to take	169

Background to Wythenshawe Hospital

Wythenshawe Hospital is the main district general hospital site, located in Wythenshawe, South Manchester, which hosts the accident and emergency department.

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

Surgical services provide a wide range of services to local and regional populations, which include the regional unit for burns and plastics and heart and lung transplants. Services for the local population include vascular surgery, gastrointestinal surgery, colorectal surgery, breast surgery, ear nose and throat surgery and trauma and elective orthopaedics. There are a wide range of procedures carried out including in-patient surgery, day case surgery and minor procedures.

The adult intensive care unit provides care for up to 17 patients, including nine level three (intensive care) patients and six level two (high dependency) patients. The burns unit has a separate intensive care unit for up to five patients with two intensive care beds and up to three high dependency beds.

The North West Heart Centre is located at the hospital and includes a 26-bedded cardiothoracic critical care unit that could be increased to 31 beds when required. This includes two beds funded for extracorporeal membrane oxygenation (ECMO) patients. ECMOis used when a patient has a serious condition which prevents the lungs or heart from working normally.

The maternity service has a total of 64 maternity beds, with only half occupied most of the time. The service consists of an obstetric consultant-led Delivery Suite with 12 delivery rooms, ten with en-suite facilities. There are two operating theatres.

The paediatric ward comprised of a 24 bedded inpatient unit (including a high dependency unit), a 10 bedded paediatric observation and assessment unit, an eight bedded day case unit and an outpatients department caring for children aged 0-17 years of age in a child and family friendly environment. The day case unit was based on Starlight ward and treated patients who attended for minor procedures.

The children's service offered a wide range of clinical provision; this included paediatric medicine and services in epilepsy, diabetes, cystic fibrosis, allergy, neonatal and cardiac service. There was a high dependency unit (HDU) and the surgical team performed surgery in an array of specialities such as ear, nose and throat (ENT), orthopaedics, general surgery, plastic surgery and maxillofacial. The service also had child psychiatry

Detailed findings

services. The starlight ward provided for in-patients and their siblings with a playroom, sensory room and a teen zone all of which met the needs of children visiting the service.

End of life care services included the specialist palliative care team which was an integrated hospital and community team, the trust's multi-faith chaplaincy service, the patient experience team, porterage bereavement team and histopathology services were also involved in providing end of life care.

There was a Macmillan care centre in the hospital and specialist palliative care outpatient support available at the Neil Cliffe centre situated in the grounds of Wythenshawe hospital.

A range of outpatient and diagnostic services are provided at Wythenshawe Hospital. A number of outpatient appointments are also offered at community locations.

Wythenshawe hospital is home to the North West Heart Centre and also the Nightingale Centre which is purpose built and provides a clinical service for breast cancer screening and diagnosis. The building includes the Genesis Breast Cancer Prevention Centre for research into prevention, screening and early diagnosis.

Wythenshawe Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities including cardiology, respiratory medicine, breast surgery, gynaecology, dermatology, pain management, trauma and orthopaedics, maxillo-facial surgery, audiology and therapy services.

Wythenshawe Hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI), ultrasound and mammography.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Inspection Manger (lead): Lorraine Bolam, Care Quality Commission

The team included two CQC Inspection Managers, 13 CQC inspectors and a variety of specialists including Junior doctor, NHS Consultant, Emergency Department Doctor and Nurse, Consultant physician, Clinical Nurse Specialist: Infection Prevention & Control, Consultant Haematologist, Surgeon, Lead Specialist Nurse, Midwife, Consultant Obstetrician, Midwifery Nurse, Consultant Paediatrician and Paediatric Nurse Consultant, a Head of Safeguarding, a Senior Governance and Risk Manager, Allied Health Professional, Senior Nurse Practitioner, Clinical Governance lead, Emergency Department nurse specialist and consultant, a Critical Care nurse, Specialist Occupational Therapist, an End of Life Nurse Specialist, a student nurse and a Health Care Assistant.

We had two Experts by Experience on the team and held a listening event on 21 January 2016 which was attended by a number of local people who had experienced the services at the trust.

How we carried out this inspection

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

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

The inspection team inspected the following core services at the Wythenshawe Hospital:

- Emergency Department
- Critical Care

Detailed findings

- Children and Young People
- End of Life
- Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We received feedback through focus groups. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at University Hospitals of South Manchester.

Facts and data about Wythenshawe Hospital

Between October 2014 and October 2015, the ED saw 95,487 patients. Approximately 21% of these patients were children (up to 16 years old). Thirty-one percent of patients who attended the ED were admitted which is above the England average (22%).

Last year, within surgical services there were 33,000 episodes of care. The majority of these were day cases (44%) with 28% emergency cases and 27% elective care. Surgical services spanned 14 wards, six acute theatres, cardiac theatres and minor procedures.

The trust supported 4421 births between 1 January and 31 December 2015, with an average of 368 births a month. This represented a 4.6% increase on the year before. The maternity performance dashboard indicates that an upper limit, or cap on bookings, has been set currently at 380 births occurring on two consecutive months.

Between July 2014 and June 2015, 5,981 children aged between 0 - 17 year olds were seen by the children's service.

During 2014 -15 the end of life team saw 1453 referrals which included patients with skin cancer, pulmonary cancer and upper gastrointestinal cancer.

Hospital episode statistics data (HES) for July 2014 to June 2015 showed 606,829 outpatient appointments were offered across the trust with 492,552 offered at Wythenshawe Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

Emergency services are provided at Wythenshawe Hospital by the emergency department (ED), which is run under the trust's urgent care directorate and unscheduled care division.

The service operates 24 hours a day, seven days a week. Between 1st November 2014 and 31st October 2015, the ED saw 95,748 patients. Approximately 19% of these patients were children (up to 16 years old). The equates to an average of 211 adult and 51 child attendances each day (262 total attendances per day). Thirty-two percent of patients who attended the ED were admitted which is above the England average (22%).

The hospital has a designated trauma centre which operates between 08.00 and 23.45 every day. Outside of these times, the most severely injured patients (except for burns injuries) are taken by ambulance or helicopter to the nearest trauma centre at Salford Royal Infirmary, if their condition allows them to travel. If not, they will be stabilised at Wythenshawe Hospital and then treated or transferred in line with their needs. The hospital has a regional specialist burns unit, providing specialist care for patients who have sustained burns injuries. The department has a helipad.

Patients arriving by ambulance are triaged in one of three bays. Ambulatory patients are triaged in one of two triage areas. Patients then receive care in one of four main areas: 'paediatrics' 'urgent care' (minors), 'majors' and resuscitation bays.

The paediatrics area has six treatment cubicles including a resuscitation room, where children up to the age of 16 years can be assessed and cared for.

Patients with minor illnesses or injuries are assessed in the minors and urgent care areas which have 11 bays in total. (six minors cubicles and five urgent care cubicles).

Patients with more serious illness or injury are cared for in the 'majors' area which has 12 bays or the resuscitation area which has six bays (including a paediatric bay). There are three entry points to the resuscitation area dependent upon whether patients are brought in by ambulance, helicopter or via the main triage area. A relatives' room and a quiet room are situated opposite the resuscitation area.

The department has a 12 bedded clinical decision unit (CDU) where patients can stay for observation whilst waiting for treatment, tests or transport home. There is also an Acute Medical Receiving Unit (AMRU). GPs or ED staff may refer patients here between 8am and 7pm Monday to Friday.

The ED also has access to two x-ray and two computerised tomography (CT) scanners as well as a clean procedure room, an eye room and a plaster room.

During the inspection we spoke with 25 patients and 16 staff from different disciplines including doctors, nurses, matrons, cleaners, administrators and allied health professionals. We reviewed 17 patient records and observed daily activity and practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Urgent and emergency services

Summary of findings

We have given Urgent and Emergency care services at Wythenshawe Hospital an overall rating of requires improvement.

There was a culture of reporting and sharing learning. Staff were open and honest in their approach to care. The department was visibly clean and tidy except for two rooms where we found dust and debris on the floor. Cleaning staff were present on a daily basis and the trust monitored cleanliness and infection prevention and control, but records were not available to assure us that cleaning of required areas took place daily.

The ED regularly saw more patients than the infrastructure was built to accommodate. Despite this, it was fit for purpose and staff were innovative in appropriately using space to accommodate patients. However entry to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access.

Medicines were within expiry date and stored in an organised way with appropriate checks in place to ensure proper use. Fridges storing medicines requiring storage at low temperature were within the correct range but the trust were unable to provide a comprehensive history of completed checks. This meant we were unable to confirm that regular checks were always completed.

Records were stored securely and contained comprehensive details about patients. Where we found an issue relating to notes in one mental health patient record, staff acknowledged the problem and described the action they would take to address it. Patients were assessed for pain and treatment was provided when appropriate.

The trust had a central safeguarding team and safeguarding link nurses with specialist knowledge worked in the ED. However, not enough staff were up to date with safeguarding training and compliance with other mandatory training was also low in most staff groups.

Staff managed patient risk using a rapid assessment and treatment model and a triage system. Patients deemed to be more seriously ill were escalated for senior medical care. Some treatments were instigated during initial assessment.

Staffing was adequate and vacancies were handled through recruitment and agency or locum staff. However, between April 2014 and March 2015, the department relied heavily on locums to fill an average of 28% of medical shifts. There were four vacancies in paediatric nurse staffing but recruitment was in progress.

Major incident equipment was fit for purpose and regularly checked. Regular major incident training took place.

Equipment was stored in an organised way, within expiry date. Checklists helped ensure equipment was available in treatment areas. However, there was no standardised process to confirm missing equipment had been replaced and we found some equipment in opened packages or in no packaging at all.

Staff cared for patients using national and local guidelines and pathways which were regularly reviewed. Food and refreshment was available but not always offered to patients and visitors. Local and national audits were undertaken. Whilst we saw some work to improve results over time, we found one example where despite poor audit results the trust did not take action.

The trust used a corporate staff induction process for new starters. Local induction also took place. Appraisal rates were considerably lower than the trust target of 85% and staff cited high activity as the cause.

Staff from different disciplines worked together to provide services for patients and had access to the information they required. We saw evidence that patient consent was obtained. Mental health trained staff were available to assess patients under the mental health act 2005 and other staff understood the principles of the act.

Although the main ED was open 24 hours a day seven days a week, 365 days a year, not all services operated at evenings or weekends.

Urgent and emergency services

Staff were friendly, helpful and respectful, introducing themselves to patients who said they felt informed about their care. In a patient survey in December 2015, 85% of patients said they were likely or extremely likely to recommend the service to friends and family.

Staff dealt with patients sensitively and in a caring way. There was a system in place to identify patients who had passed away and link nurses provided specialist support for bereaved relatives or loved ones.

Staff were familiar with people using services. Language interpretation, sign language and multi faith rooms were available. Link nurses provided specialist knowledge in areas such as dementia, alcohol misuse and safeguarding. Leaflets were available for patients to use as a reference following discharge from the ED.

Access and flow remained a problem. The ED had not met the target to see, treat, admit or discharge patients within four hours at all in the last 12 months. Despite this a number of initiatives were in place to try to address this.

Verbal complaints were dealt with at the time if possible through communication and reassurance. We saw evidence that formal complaints were investigated and action taken to resolve them and limit recurrence.

There was a strategy in place for the future and staff were aware of plans to expand the ED over the next three years.

Governance, risk and quality was measured and recorded appropriately, and discussed on a monthly basis in formal meetings. The department had a risk register with risk ratings, actions to mitigate risk, and review dates. However we saw that risks relating to reception staff in the ED were not recorded.

Staff felt well supported by leaders and described a positive team culture with good staff engagement. Staff thought innovatively about improving access and flow and the department itself through accreditation schemes.

Are urgent and emergency services safe?

Requires improvement

This inspection has resulted in a rating of requires improvement in protecting people from abuse and avoidable harm.

The department was visibly clean and tidy except for a room used for mental health patients and a store room which were dusty. Despite cleaning staff being present on a daily basis, with a list of cleaning duties, they did not keep records to show what cleaning had taken place. This meant there was no way of knowing whether cleaning lists were being regularly completed. However, the trust monitored cleanliness and infection prevention and control on a monthly basis, providing reports to highlight any issues.

Entry to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access. We also noted that vents in the ceiling of a room used for mental health patients could pose a ligature risk.

Fridges storing medicines at low temperature were within the correct temperature range but the trust was unable to provide us with comprehensive records of temperature range checks. Other medicines were stored in an organised way and within expiry date. Controlled drug stocks were checked and correctly recorded.

Equipment was stored in an organised way, within expiry date. Checklists were used to record equipment stock levels in treatment areas. However, there was no standardised process to confirm missing equipment had been replaced. We reviewed equipment checklists which staff said were completed daily but found nine out of 27 dates were missing in the resuscitation area.

We also found some packaging containing items such as laryngoscope blades was open rather than remaining sealed until use. Three paediatric breathing masks were completely unpackaged and we were unable to locate paediatric forceps. Staff reported that because equipment was originally packaged as ‘clean’ rather than ‘sterile’, the need to keep it sealed was lessoned. Despite this, we were concerned that this increased the risk that equipment might not remain clean prior to use.

Urgent and emergency services

The trust had a central safeguarding team and safeguarding link nurses with specialist knowledge worked in the ED. Despite this, not enough staff were up to date with safeguarding training. Additionally, compliance with mandatory training in nurses and doctors did not meet the trust target of 85%.

Staffing was adequate and vacancies were handled through recruitment and agency or locum staff. However between April 2014 and March 2015, locum doctors covered 28% of medical staffing. Paediatric nurse staffing was the main concern but recruitment was in progress and actions were taken to mitigate identified risks.

Records were stored securely and contained comprehensive details about patients. Where we found an issue relating to notes in one mental health patient record, staff acknowledged the problem and described the action they would take to address it.

Staff used tools to manage patient risk and monitor deterioration, including a rapid assessment and treatment model and a triage system. Patients deemed to be more seriously ill were escalated for senior medical care. Some treatments were instigated during initial assessment.

The ED regularly saw more patients than the infrastructure was built to accommodate. Despite this, there were areas for patients to wait or receive treatment and care, and staff were innovative in appropriately using space to accommodate patients.

Major incident equipment was stored outside the main ED. This was fit for purpose and regularly checked. Regular training took place and staff knew what to do should a major incident be declared.

There was a culture of reporting and sharing learning following incidents. Staff were open and honest in their approach to care.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Incidents were reported electronically and staff received email receipts following submission.
- Between July and October 2015 the department reported 521 incidents, 517 of which resulted in minimal or no harm.
- Five serious incidents were recorded by the trust between October 2014 and September 2015. These related to delays in diagnosis or treatment, adverse media coverage and a patient harming themselves.
- Senior staff acted as 'family liaison' leads for patients and loved ones involved in incidents.
- Incident records included description of the incidents, the level of harm sustained, investigation timelines and actions. Serious incidents were investigated using root cause analysis.
- Outcomes were fed back to the staff involved and learning was shared in meetings or displayed on noticeboards in staff areas.
- Senior staff were aware of the Duty of Candour process and we saw evidence that this was implemented. The Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in care that led to significant harm.
- Mortality was discussed divisionally on a monthly basis. Reviewing mortality helps promote learning and provides assurance that patients are not dying as a result of unsafe care.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy except for a store room and a room designed for mental health patients. In these rooms we saw dust and debris on the floor.
- In the CQC Accident and Emergency patient survey 2014 patients rated the department eight out of ten for cleanliness
- Cleaning staff used laminated task lists for cleaning each area. They explained that tasks were completed when areas were accessible and that toys were cleaned at least once weekly. The tasks included damp dusting surfaces and cleaning floors. Other duties such as cleaning trolleys were done by ED staff.
- Cleaning staff said they did not keep a record of which areas had been cleaned. As there were no records for us to review we could not corroborate what staff told us about cleaning practice each day.
- However, the department was reviewed each month for cleanliness and hygiene by a central team and these findings were recorded. In September and October 2015 the department scored 89%. Areas reviewed included

hand hygiene and clinical practice, cleanliness of equipment and the general environment. Actions were taken to address low compliance such as reminders for staff and daily checks by senior staff.
- Hand sanitizers were available throughout the department.

Environment and equipment

- The ED infrastructure was due to be extended in order to cope with the number of patients attending the ED. A project team met monthly to discuss the plans and associated actions. The first phase began in January 2016.
- Patients attending the ED by ambulance entered through a separate entrance from ambulatory patients. Entry to the paediatric ED was via an unlocked door, which posed a risk of unauthorised access. The risk was mitigated because people entering the area had to walk past the nurses' station; however staff were not always present. We noted that the issue was not recorded on the department risk register either.
- Inside the paediatric area there were books, toys and children's television. There was no area for adolescents and no quiet rooms for loved ones; however clinical staff working in the department told us that a room could be arranged for older children or loved ones to wait away from the main waiting area if available.
- There was a room in the main ED designed for mental health patients to wait for specialised care. The room had windows to allow monitoring, fixed furniture and two entry/exit points. There were air vents in the ceiling which we were concerned could be a ligature risk. We asked a consultant and matron about this, who confirmed that this room had been risk assessed for ligature points and that this had not been identified as an issue. They also confirmed that patients staying in this room were under constant observation by security staff or staff at the nurse's station. Despite this staff acknowledged the vents could be covered to mitigate any future risk.
- The waiting area outside the x-ray and computerised tomography (CT) scan rooms consisted of four seats for ambulatory patients. However patients on stretchers had to wait on the corridor rather than in a designated area away from public areas.
- The dirty utility room where commodes were cleaned and stored was clean and tidy. Equipment was labelled to indicate when it had last been cleaned.
- Equipment was checked and maintained by the trust medical engineering department, or external companies. The trust had a policy in place to support this process.
- We examined adult and paediatric equipment in the resuscitation area. The equipment we inspected was within expiry dates and generally stored in an organised way. However, we could not locate paediatric forceps and found three unpackaged paediatric breathing masks amongst the equipment. We also found a pair of adult forceps out of the packaging and laryngoscope blades in opened packaging. We discussed this with nursing staff who said this ensured the equipment was ready for use and that the equipment was originally packaged as 'clean' rather than 'sterile' which limited the need for packaging to remain sealed until needed. We were concerned about the risk of equipment becoming less clean than it should be prior to use.
- A hoist was available in the ED which all nurses were trained to use.
- A daily equipment checklist was in place in the resuscitation area. We reviewed this and found that between 1 and 27 January 2016, nine dates were missing. We also found that, whilst missing items were noted, there was nowhere to record whether items had been replaced. We made a nursing sister aware of our findings. She suggested that some staff used a tick to indicate items had been replaced and that the solution might be to ensure this was done by all staff.
- We checked major incident equipment which was stored securely outside the main ED. The equipment was in date and records showed it was checked regularly.

Medicines

- We checked medicines and controlled drugs in the emergency department. These were within date and stored in an organised way. For example, drugs for medical teams to use if called to attend an incident outside the hospital, and medicines used for mental health patients were stored separately.
- Controlled drugs were checked daily and usage was correctly documented.
- Fridges used to store medicines at low temperature in the main area were checked and displayed the correct temperature. We saw a document where staff recorded temperature checks but this had only been started the day prior to our inspection. We asked staff to provide

records for dates prior to this and received one document recording dates for an unidentified area in December 2015. They stated that some records may have been lost.
- Four nursing staff were trained to prescribe certain medicines. Two other staff were due to qualify and two more were working towards prescribing qualifications.
- Other nursing staff used patient group directives (PGDs) to provide medicine for patients. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available.

Records

- Patient records were in paper format and stored securely behind the reception desk in a closed office. Following discharge, records were scanned into the system to be used for future reference.
- We reviewed 17 patient records (including six paediatric records) during our inspection. The records were legible with details of the presenting complaint, observations, timings, risk assessments for safeguarding, pressure sores, social circumstances, and treatment plans.

Safeguarding

- Safeguarding training was mandatory. Staff completed different levels of training based on the level of contact they had with patients. All administrative staff were up to date with level one basic safeguarding training. Only 78% of nursing staff had completed level two adult safeguarding and 75% had completed child safeguarding training which did not meet the trust target of 85%. Paediatric ED nursing staff did meet the trust target with 90% up to date with adult safeguarding training and 100% up to date with child safeguarding training. Medical staff did not meet the target for level two adult safeguarding training (71%) but did meet it for child safeguarding training (86%).
- The trust safeguarding team were available between 9am and 5pm on weekdays.
- Link nurses worked within the ED to provide advice and support for staff, as required.
- Safeguarding concerns about patients were entered onto the IT system in the ED and were then visible to staff providing care.
- Safeguarding assessments were done for all children and records we reviewed reflected this.

Mandatory training

- Practice development facilitators, the matron and ED manager worked to ensure staff training was up to date. Individual training compliance figures for staff could be viewed instantly on the trust intranet and senior staff showed us how they did this.
- Teaching sessions were delivered throughout the year, covering a range of topics including dementia awareness, fire safety, resuscitation, infection prevention, equality and diversity, safeguarding and conflict resolution.
- The trust target for mandatory training completion was 85%. Administration staff met this target with 96% of staff up to date. However nursing and medical staff did not meet the target with an average compliance figure of 76%. The lowest areas of compliance for nurses was in fire safety (67%), infection prevention (68%) and moving and handling training (68%). Medical staff had the lowest levels of training in learning disability awareness level 1 (68%), medicines management (57%), moving and handling (64%) and venous thromboembolism (57%).
- Senior staff were aware of the need to ensure staff remained up to date with mandatory training but described difficulties balancing this with ensuring staff were available to care for patients during busy periods. They explained that staff completed mandatory training when possible during quiet periods and we saw this in practice during our inspection.

Assessing and responding to patient risk

- Staff managed risks to patients by following processes and using tools to triage and assess patients. These included the Manchester Triage System (MTS) and an Early Warning Score (EWS) system. EWS systems analyse clinical observations within set parameters to determine how unwell a patient may be. When observations fall outside parameters they produce a higher score, requiring more urgent clinical care than others. A EWS score was completed during initial assessment and displayed on the main IT system. The trust had an escalation procedure for patients with raised EWS scores. Actions included increasing the frequency of observations and escalating the issue to a doctor.
- During a review of patient records we found that EWS was not always recorded. Out of 17 records, seven did not include an EWS. The trust confirmed that EWS was

not always recorded. For example, for patients with minor illness or injury. The matron told us that audits of the triage process were completed regularly (ten records per staff member annually), with supervised practice implemented where audits highlighted poor practice. Results for July 2015 showed that an EWS was recorded in all records audited, with 96% accuracy.

- The MTS tool aims to reduce risk through triage, ensuring patients are seen in order of clinical priority and not in order of attendance. We observed the triage process where staff took comprehensive details about medical history, presenting complaint, pain score, and made requests for tests or further medical intervention. Only experienced nurses worked in the triage area and there was a standard operating procedure to support them.
- The ED used a rapid assessment and treatment (RAT) model to ensure assessment and treatment commenced as soon as possible. The College of Emergency Medicine states that 'a rapid assessment should be made to identify or rule out life threatening conditions and ensure patient safety' (triage position statement April 2011).
- Call bells were available for patients to request assistance should they need to but they were not always placed on patients' beds. However some patients told us they did not need the buzzer or had moved it out of the way themselves.

Nursing staffing

- The ED assigned different grades of nursing staff to areas of the ED in an organised way. They included staff nurses, sisters, a matron, and emergency and advanced nurse practitioners.
- Senior nurses used a staffing tool developed by the Royal College of Nurses (RCN) and researched neighbouring trusts to source ideas about staffing adult and paediatric areas of the ED.
- Senior staff described staffing as adequate except for in the paediatric area. Here, eight paediatric nurses were employed and there were four vacancies. Three attempts to recruit had been made, and so far three vacancies had been filled. In the meantime a risk assessment had been completed in relation to paediatric nurse staffing and staffing levels were incorporated into the trust patient flow escalation policy for staff to refer to when levels were low.
- Vacancies were reflected in the fill rates provided by the trust. Fill rates provide a percentage of staff on duty against establishment. Between July and October 2015 fill rates in the main ED ranged between 98% and 111%. However fill rates for the paediatric ED ranged between 71% and 101%. The matron explained that the vacancies in paediatrics were balanced by increasing the numbers of general nurses or using agency staff. Between March 2015 and January 2016 the department requested agency paediatric nurses 76 times.
- The overall use of agency nurses had fallen over time from 17% in April 2014 to 4% in February 2015.
- Nurses providing care for children were trained in emergency paediatric life support. Staff told us training was done on a rolling basis and records showed six nurses had received this training within the last 12 months.
- Allied Health Professionals (AHPs) were employed within the ED. Records showed that between July and October 2015, staffing levels for AHPs were in line with establishment.
- Sickness absence rates for nurses in the ED between April 2014 and March 2015 were 4.8%, which was slightly higher than the average sickness rate for NHS staff in England (4.4% between January and March 2015).
- Handovers and ward rounds took place on a four hourly basis from 8am until 10pm. These were attended by a range of staff including doctors, allied health professionals and nurses.

Medical staffing

- Thirteen consultants were employed in the directorate (10.3 whole time equivalent staff) but there was funding for 15. However, staff confirmed that funding was last calculated when the department held full time major trauma centre status. At the time of our inspection, major trauma patients were only accepted by the centre during the day.
- Staff managing medical rotas said medics were flexible and there were few issues. However, we saw figures which showed that between April 2014 and March 2015 the average rate of locum staff in the ED was 28%. Staff responsible for rota management confirmed that this was due to increased activity, national vacancies, and maternity or annual leave.
- To assure ourselves about medical staffing in the ED, we reviewed staffing levels which were recorded and

monitored using a spreadsheet. Medical staffing records between 9 and 15 November 2015 showed that staffing levels were in line with or above establishment each day.

- Consultant cover was available for 16 hours each day between 8am and midnight. After midnight consultants were available on an on call basis.
- Two consultants had paediatric training. The trust confirmed that additional paediatric trained consultant cover was provided 24 hours per day by six consultants and 11 registrars who worked for the paediatric department who covered wards and supported the ED.
- Staff used triggers to escalate staffing issues. They explained that if two doctors were absent, staff tried to source other staff (including locums). If three doctors were absent, staff sought authorisation to raise the rate of pay for replacement staff.
- Sickness rates amongst medical staff between April 2014 and March 2015 was 0.4%, lower than the NHS average. (4.4% between January and March 2015).
- Handovers took place on a four hourly basis from 8am until 10pm with an additional handover at midnight when consultants went home. We observed a handover take place which was led by a consultant and well attended by a range of nurses and doctors. All patients in the department were discussed.

Major incident awareness and training

- The trust had an up to date policy and plans for major incidents. The trust also had business continuity plans to manage disruption to services such as fire, or procurement issues, as well as plans to manage pandemics or other outbreaks.
- Major incident action cards were available for staff which contained clear instructions, roles and responsibilities for staff assigned to different areas.
- Staff were trained for major incidents and 38 staff received training in 2015. The most recent simulation exercise took place in September 2015. Learning points such as delays transferring patients to wards were noted, along with ideas for overcoming issues (such as identifying staff to help transfer patients).
- Staff were also trained to manage patients presenting with infectious diseases such as Ebola or Middle East Respiratory Syndrome (MERS). These are serious diseases originating in Africa and the Middle East. We saw staff preparing to receive a patient with suspected MERS. They wore appropriate protective equipment and access to the patient was restricted with warning signs.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We have rated urgent and emergency services as requiring improvement in providing effective care for patients.

Patient outcomes were measured through audits at both national and local level. Following poor results for sepsis care, the department had worked to improve this which was reflected in audit results which showed some improvement. However we were less assured about the work done to improve audit results in other areas such as care for children suffering fits, or mental healthcare. This was because action plans shown to us did not always acknowledge requirements to improve or include deadlines for implementing changes, and senior medical staff were not always aware of areas requiring improvement.

Re-attendance rates within seven days of discharge were consistently higher than the Department of Health target of 5%.

Although the main ED was open 24 hours a day seven days a week, 365 days a year, not all services operated at evenings or weekends.

We saw evidence of pain being assessed and treated, and there were arrangements in place to ensure staff could provide food and drinks to people in the department. However not all the patients we spoke to had been offered food or refreshment.

The trust had a process for inducting staff and local induction also took place but appraisal rates were considerably lower than the trust target of 85%.

Staff cared for patients using national and local guidelines and pathways which were regularly reviewed. Staff from different disciplines worked together to provide services for patients and had access to the information they required.

Urgent and emergency services

Staff understood the principles of depriving a person of their liberty. We saw evidence that patient consent was obtained and that staff understood the mental health act 2005.

Evidence-based care and treatment

- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) such as NG50 guidance for recognising and responding to deteriorating patients.
- Staff also used local care pathways, based on NICE guidance and the findings of audits by the College of Emergency Medicine (CEM). These included a paediatric pathway for the treatment of diabetic ketoacidosis, an adult pathway for the treatment of head injury and sepsis care guidelines. We saw evidence that pathways were reviewed during regular departmental meetings.
- Protocols were used by staff requesting blood tests which were supplemented by the use of colour coded request forms. This made it easier to differentiate urgent and routine requests.
- Monthly local audits were done to monitor compliance and track improvements. For example, sepsis care audits in 2012 showed that it took approximately four and a half hours to administer antibiotics. This improved to an average of two hours fifty minutes in 2014. Local audits also highlighted areas for improvement such as recording early warning scores.

Pain relief

- In the Accident and Emergency (A&E) patient survey 2014 the ED scored seven out of 10 for doing everything possible to help control pain.
- Patients we spoke to said staff were conscious of and took steps to minimise the level of pain they were experiencing.
- Nurses responsible for triaging patients were able to administer pain relief during initial assessment.
- We saw evidence of pain relief being offered to patients in records.

Nutrition and hydration

- ED staff had access to kitchens to provide food and refreshment for patients. Some food was stored for patients or additional orders were made by contacting dining services by telephone.
- Despite this, five out of 14 patients we spoke to reported not being offered food or refreshment. One patient we spoke to told us he had been in the department for approximately 12 hours but it was not until the final hour that he was brought a drink.
- In the CQC A&E patient survey 2014, the department scored 6.5 out of ten for ensuring patients were able to get suitable food or drinks. This was about the same as other NHS trusts surveyed.
- Snacks and cold refreshments were available from vending machines in the main waiting area. These were fully stocked at the time of our inspection.

Patient outcomes

- The trust participated in national audit programmes by the College of Emergency Medicine (CEM) for severe sepsis and septic shock (2013/14), the initial management of fitting children (2014/15) and mental health in the ED (2014/15).
- The audit of severe sepsis and septic shock highlighted areas for improvement. For example, high flow oxygen was found to be administered in only 32% of patients (against a target of 100%) and fluids were only administered to 22% of patients within one hour of arrival (against a target of 75%). To improve standards, the trust delivered presentations to staff promoting sepsis care, and monitored performance on a monthly basis. By 2015, results showed improvement. For example, high flow oxygen was found to be administered in 85% of patients and fluids administered to 56% of patients within one hour.
- The initial management of fitting children audit showed that all patients had presumed causes recorded but only 90% had an eye witness history recorded and only 33% of parents/carers were provided with written safety information about seizures at the point of discharge. Recommended actions from this audit were to provide education for staff and to re-audit, but there was no date to suggest when the actions would be implemented. Whilst a consultant explained that it had not been possible to re-audit care due to a small sample size (approximately one child per year admitted under audit criteria), it also transpired that the consultant was unaware of the issues highlighted by the audit.
- The audit of mental health care showed that against targets of 100%, only 82% of patient risk assessments were recorded in notes, and only 5% of patients

received assessment by a mental health practitioner within one hour. A trust document stated that proformas were used to help staff record pertinent details and staff told us that a new mental health staff lead was due to start work in February 2016 which they felt would improve mental healthcare. We noted that the trust also had a mental health steering group in place. However, the trust document also stated that patients received prompt mental health input and that no further action was necessary to raise standards. This concerned us, given that neither of these targets was reached by the trust.

- The department audited other aspects of care locally to ensure standards were maintained. For example, use of the modified early warning score system was audited monthly by reviewing a random sample of ten patient records and results were good. Against a compliance target of 95%, staff recorded a full set of clinical observations in 99% of records and included a correctly calculated MEWS 96% (July 2015).Activation of the escalation procedure for raised MEWS scores was also audited. In July 2015 the results showed that staff correctly increased the frequency of clinical observations in 95% of cases for patients with a MEWS of one or two, and in all cases when the MEWS was three or more.
- The trust monitored outcomes in terms of the number of patients who unexpectedly re-attended the ED within seven days of discharge. Between July 2014 and July 2015 the figures were consistently above the department of health standard of 5%, with approximately 7% of patients re-attending.

Competent staff

- The trust took steps to ensure that staff were competent to work in the hospital. For example, new staff were given a two day corporate induction covering general employment information. Junior doctors told us an induction booklet was provided as well as IT access. They also told us that consultants showed them around the department, introduced them to staff and showed them where pathways and policies were kept.
- New nursing staff underwent a four week ED induction where topics such as equipment use and departmental procedures were covered. We saw an induction folder which contained comprehensive information such as policies, protocols and resources. Staff were expected to work through the folder prior to finishing their induction. Following this, they worked on a supernumery basis initially, before becoming substantive. Two link nurses provided support for new starters.
- Consultants providing care for children were trained in advanced paediatric life support which was taught on a rolling basis. Records showed that three consultants had received this training within the last 12 months.
- Appraisal rates for ED staff did not meet the trust target of 85%. Between April and October 2015, the trust reported that only 68% of administrative and clerical staff, 40% of nursing staff and 80% of medical staff had received their appraisal. The matron reported difficulties completing appraisals when activity in the ED was high.

Multidisciplinary working

- A range of nurses and medical staff with specialist knowledge worked in the ED to provide holistic care for patients. They included alcohol misuse nurses, physiotherapists, occupational therapists, specialists in geriatric medicine and a play specialist.
- The ED had developed a joint strategy with a local specialist cancer centre, to provide care for cancer patients suffering with possible neutropenic sepsis (a serious complication of anticancer and immunological treatment). This allowed nurses to administer antibiotics under strict criteria, ensuring treatment commenced quickly.
- Trust staff worked collaboratively with a local GP Federation to provide a primary care service based in the ED. This enabled ED staff to allocate a limited number of patients to GPs, where appropriate.
- We observed a daily Strategic Review Operational Group (SROG) meeting. Representatives from the local clinical commissioning group, the council, trust staff involved in patient flow, performance management, as well as clinical staff from the unscheduled and scheduled care divisions attended. We saw them working together to maintain a focus on patient flow through the hospital, reviewing strategies to ensure successful recruitment and seasonal plans. They also discussed ideas for managing staffing during peak periods, reviewed recommendations to improve flow and strategies adopted by other local trusts.
- The Older Person's Assessment and Liaison (OPAL) team provided specialist care for older people. The team consisted of consultants, physiotherapists and

occupational therapists who worked Monday to Friday between 10am and 6pm in the ED to provide specialist assessments and support to older patients who may benefit from alternative care (such as social care or rehabilitation) or admission to hospital. The team proactively identified suitable patients and saw approximately seven patients each day.

- ED staff liaised with the local ambulance service NHS trust who kept them informed of the acuity of patients who may attend the ED in the coming hours.
- The mental health liaison team worked closely with ED staff to provide care and assessment for mental health patients. Staff described a very positive relationship with the team.
- The trust worked within regional networks to provide the best care for patients suffering with certain types of stroke or myocardial infarction (the trust was a specialist centre for myocardial infarction). If patients attending the ED met set criteria for stroke or myocardial infarction, they were transferred to or from neighbouring hospitals depending on their diagnosis and the time of day.

Seven-day services

- The ED was open 24 hours a day seven days a week, 365 days per year. However some services within the ED were not available at all times. For example, the alcohol team worked between 8am and 5pm Monday to Friday and the Older Persons Assessment and Liaison (OPAL) Service was open between 10am and 6pm Monday to Friday (with consideration at the time of inspection, to extending this to seven days a week) and referral to the rapid access clinics only took place between 8am and 5pm Monday to Friday.
- Magnetic resonance and vascular scan imaging were not available at weekends. This meant that sometimes during very busy periods these services were less accessible which could impact on wait times for patients.

Access to information

- Staff accessed IT systems to source information about patients. These included the main ED system which held details about previous visits, a Picture Archiving and Communication system (PACS) which allowed staff to view scans taken anywhere in the region, and a system owned by the local specialist cancer centre which allowed staff to review the medical history of cancer patients. Staff told us the systems were reliable but that back up paper systems were in place should systems fail.
- Staff could source specialist information about topics such as dementia or safeguarding from link nurses based in the department.
- Staff also had access to information about activity in the ED such as the number of patients seen, the number of breaches of the four hour target, which patients were waiting for admission and which patients were ready for discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff explained the process for caring for mental health patients which included referral to a mental health liaison team, requesting security or additional healthcare assistants to provide one to one care or increased monitoring.
- We reviewed two records relating to mental health patients. One of these noted concerns that the patient lacked mental capacity. However, we found no evidence of a formal capacity assessment. We later found evidence of this in separate records belonging to the mental health liaison team. The matron acknowledged the assessment should have been duplicated in the ED record. The notes also stated that security staff were summoned to prevent the patient leaving the ED. However without evidence of sectioning under the Mental Capacity Act 2005 or application for deprivation of liberty safeguards we were concerned that detention at that time may have been unlawful. The matron told us that whilst the notes implied detention without legal cause, she was satisfied staff knew patients could leave under these circumstances. She suggested staff may have tried to persuade the patient to stay but would liaise with the mental health liaison team and communicate learning to staff to ensure record keeping accurately reflected what occurred.
- The trust had a policy to support staff delivering care under Deprivation of Liberty Safeguards.
- Deprivation of Liberty Safeguards training was provided for staff as part of the mandatory safeguarding training every three years.
- We saw staff seek verbal consent from patients after providing a full explanation and confirming confidentiality.

Urgent and emergency services

Are urgent and emergency services caring?

Good

Staff were friendly, helpful and respectful and introduced themselves to patients who said they felt informed about their care.

Of the patients surveyed in the Trust's Friends and Family questionnaire in December 2015, 85% said they were likely or extremely likely to recommend the service to friends and family.

There were leaflets available for staff to give to patients as a reference following discharge from the ED.

Staff dealt with patients sensitively and in a caring way. There was a system in place to identify patients who had passed away and link nurses provided specialist support for bereaved relatives or loved ones.

Compassionate care

- We spoke to 25 patients and visitors in the ED. Although some patients described long waits, they said staff were 'friendly' 'respectful', and 'compassionate'. Patients also said they felt welcomed by staff who were always helpful.
- Some of the people we spoke to were parents of children who had been brought to the department. They told us the care in the paediatric area was 'great' and that they were very happy with the care provided.
- We saw staff introduce themselves to patients and those close to them and build a rapport with them when providing care.
- In the CQC A&E patient survey 2014 the trust scored 8.7 for patients feeling listened to, and treated with respect and dignity. This was similar to other ED departments surveyed in England.
- In the survey patients rated the service overall as 7.8 out of ten.

Understanding and involvement of patients and those close to them

- Patients and those close to them told us they felt informed about what would be happening next whilst they were receiving care in the ED. They also said staff were nice and explained future plans in a way they could understand.
- In the CQC A&E patient survey 2014, the department scored 7.7 for patients feeling involved in decision making. The department also scored 7.1 out of ten for patients feeling they could discuss anxieties or fears with staff and scored 9.3 out of ten for patients explaining the purpose of medications to them. These scores were similar to other ED departments surveyed.

Emotional support

- Bereavement link nurses worked in the ED to provide specialist support for those who had lost a loved one.
- Staff used a 'swan' symbol to indicate when a patient had passed away. This raised awareness that loved ones who had lost someone were close by.
- We observed security staff respond to a patient with a calm and sensitive attitude when a drink was spilt.
- The trust had a 'carer's strategy' covering the period 2015-2017. The strategy outlined how involvement with carers would be improved by identifying and developing 'carers champions' (staff with specialist knowledge) and ensuring carers had access to bereavement services.

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

Requires improvement

We rated urgent and emergency services as requiring improvement for responsiveness.

Access and flow remained a problem and despite efforts to address this, the ED had not met the target to see, treat, admit or discharge patients within four hours at all in the last 12 months. A number of initiatives were in place to try to address this.

Staff were familiar with the people that used their service locally and explained how care was provided to them.

Language interpretation, sign language and multi faith rooms were available if needed. Link nurses provided specialist knowledge in areas such as dementia, alcohol misuse and safeguarding.

Complaints were dealt with at the time if possible through communication and reassurance. We saw evidence that formal complaints were investigated and action was taken to resolve them and limit recurrence.

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of the local community. They explained that some patients attended straight from a nearby international airport and that interpreter services were available. Staff told us they did not use family members to interpret, which mitigated the risk of misinterpretation.
- The ED had a multi-faith relatives' room should loved ones prefer to spend time away from the main waiting area. Hot and cold drinks were available in this room.
- A play therapist worked in the ED for three days each week, to help support children receiving care or treatment.

Meeting people's individual needs

- Staff caring for patients with learning disabilities or complex needs were familiar with 'health passports'. Where appropriate, these were provided by patients or carers to describe patients' individual needs.
- Dementia link nurses worked in the department to care for patients living with dementia.
- The ED IT systems helped identify patients with specific needs such as learning disabilities and dementia as well as those with a history of substance misuse or domestic abuse. The system would not print out a patient record until the information had been viewed by staff which encouraged them to review the details.
- Three alcohol specialist nurses worked in the alcohol misuse service from 8am until 5pm between Monday and Friday.
- Mental health liaison staff worked 24 hours every day to provide specialist care for patients. Staff reported that current response times were usually within the hour for adults (despite audit findings for 2014/2015 stating that only 5% of patients received a response within the hour). However they acknowledged that response times were not as good for children and adolescents. They explained that the focus had been on adult mental healthcare but were confident that with the introduction of a new mental health lead in February 2016, the focus for children and adolescents would improve.
- Telephone translation services and sign language interpretation were available, if required, and could be arranged via the trust intranet system.
- A range of leaflets were available for staff to give to patients as a reference after they left the ED. These included advice about alcohol, wound care, soft tissue injury and head injury.
- Information about caring for patients approaching the end of life was available in folders in the resuscitation area. These contained information about religious and cultural beliefs.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust failed to meet this target between November 2014 and November 2015. The highest percentage of patients admitted, transferred or discharged within four hours was 94% in November 2014. The lowest was 83% in October 2015. We saw the latest action plan for January 2016, which described exploring the use of a temporary transfer lounge for patients waiting for a bed in the hospital, reviewing the role of the shift co-ordinator and expanding an area for patients to be transferred to when capacity is reached.
- The number of patients waiting between four and 12 hours for a decision to admit was similar to the England average between April 2014 and April 2015 except for a peak in August 2014. Between September 2014 and August 2015, 3314 people waited between four and 12 hours from the decision to admit being made and actual admission to a ward. One person waited longer than 12 hours during this period.
- Ambulance handover times should not exceed thirty minutes and these were regularly monitored. Between September 2015 and January 2016, there were 223 occasions when ambulance handovers took between 30 and 60 minutes. There were 102 occasions when the handovers took longer than 60 minutes. Approximately two thirds of these occurred because there were no beds in the hospital for patients to transfer to.

- Staff worked to ensure flow was maintained by completing early initial assessments of patients. This rapid assessment and treatment (RAT) model allowed staff to begin care and treatment during initial triage rather than waiting for a doctor to review patients later. Whilst the triage area was predominantly staffed by experienced nurses, consultants attended upon request. Requests could be made based on set criteria such as an early warning score of four or more, or severe pain, or if the triage nurse felt concerned in any other way. A triage nurse told us consultants were quick to respond, usually arriving within ten minutes.
- The ED could accommodate 60 patients but staff told us there were occasions when 90 patients were being cared for. Staff used initiatives called the 'ten standards for patient flow' to try to maintain a steady flow of patients through the ED and out into the hospital. These included identifying patients who could be safely seen in other areas of the hospital such as the Acute Medical Receiving Unit (AMRU) or the Clinical Decisions Unit (CDU).
- The AMRU accommodated ambulatory patients on a short term basis, accepting referrals from GPs or directly from the ED. The unit had three triage/consulting rooms and room for patients to sit during treatment.
- The Clinical Decisions Unit (CDU) had 12 beds and was open 24 hours a day. Only ED patients requiring short term clinical care were transferred here under strict criteria. For example, patients had to be able to self-mobilise, and only patients suffering with certain conditions (such as minor head injuries or to wait for test results) were admitted. The unit had one side room available for infectious patients and a seated area (with four chairs) for patients waiting for test results with the expectation of being discharged. Patients stayed for a maximum of 36 hours (80% of the time). However during our inspection in January 2016, we saw that one patient had been on the unit since December 2015. Staff told us this was unusual and caused by issues organising care home accomodation. To assure ourselves that this was not a common problem we reviewed the frequency that patients who should have been admitted to wards (called 'outliers'), were accommodated on the CDU. Between July and December 2015, the average number of outlier patients being accommodated on the CDU was 1.7 each day. There were no outlier patients for 69 days within this period.
- Nursing or medical staff referred patients to rapid access clinics for specialities such as ear, nose and throat (ENT) or burns. This could be done at the point of initial assessment.
- ED doctors conducted ward rounds in the ED every four hours until 10pm to ensure patients were constantly reviewed. Consultants from other areas of the hospital worked on an 'in-reach' basis in the ED. For example, a consultant from the acute medical unit (AMU) attended every Monday to identify patients who would benefit from care in the AMU. This helped to ensure that patients requiring admission did not stay too long in the ED before being transferred to the appropriate area.
- The trust escalation policy supported staff in escalating capacity issues through to senior level staff. Escalation meant a number of actions could be implemented. These included early morning assessment of patients suitable for transfer to the Clinical Decision Unit (CDU), notifying clinical commissioning groups, and occasionally cancellation of elective surgery.
- Trust bed meetings were held regularly throughout the day. Here, staff analysed capacity within the ED and wider hospital, and reviewed actions for maintaining flow such as assessing patients ready for discharge and sourcing extra staff.
- Breaches were analysed weekly to determine where the delay occurred and whether it could have been prevented. Where a delay could have been prevented, staff received face to face feedback to ensure learning took place.
- The ED had access to the hospital discharge lounge, where patients ready to go home could wait. This helped to ease congestion in the ED.

Learning from complaints and concerns

- Between November 2014 and October 2015, the ED received 58 complaints. The Paediatric ED and the Clinical Decision Unit received three complaints each. Complaints ranged from diagnosis delays, to the attitude of staff caring for patients.
- Formal complaints were investigated by a senior nurse or a doctor. Actions were documented and implemented such as providing an apology, undertaking reflective practice or meeting with the complainant to offer an explanation.
- Some complaints were dealt with in partnership with other organisations. For example, following a complaint about pain management staff liaised with a patient's GP

to ensure a suitable package was in place should the patient need to attend the ED again. Staff then updated the patient's record to ensure the information would be displayed in future.

- Senior nursing staff told us that verbal (informal) complaints (received at the time the issue occurred) usually related to delays. Patients and visitors we spoke to confirmed this. They described long waits in the main ED and we saw three people ask staff about delays during our visit to the department. However, parents attending the paediatric area of the ED described care as 'smooth running' and 'quick'. Staff explained that verbal complaints were dealt with at the time through communication and reassurance.
- Reception staff had access to leaflets which explained the complaints process for those who were unhappy with services.

Are urgent and emergency services well-led?

Good

We have rated services as being good for well led.

There was a strategy in place and staff were aware of plans to expand the ED over the next three years.

Governance, risk and quality were measured and recorded appropriately, and discussed on a monthly basis in formal meetings. Staff felt well supported by leaders and described a positive team culture. We saw examples of staff engagement such as senior staff visits, bulletins and social events.

Innovation focused on improving access and flow in the ED itself through accreditation schemes.

The department had a risk register in place which contained relevant information such as a risk rating, actions to mitigate the risk, and dates for review. However, we noted that the reception area was accessible to members of the public with no screens to protect them. Additionally, staff were not aware of panic buttons and security staff were not based in the department so could take longer to arrive if assistance was required. This was not noted on the risk register.

Vision and strategy for this service

- The directorate had a local strategy plan in place for 2015/16 which was built around the vision that 'effective care [would be] delivered by highly skilled, compassionate staff'. Specific goals included working to ensure the new build incorporated efficient and effective process, and to build on the specialities of department 'champions' to improve care for patients.

Governance, risk management and quality measurement

- The directorate had a risk register in place which included a description of the risk, a risk rating, review dates, actions so far and control measures.
- Reception staff were based at desks which were open to the public. Whilst they rarely experienced problems, staff told us that one incident had occurred whereby a visitor jumped over the reception desk. Staff were unsure whether panic buttons that had once been active, still worked. Additionally, security staff were not based in the ED. This meant that it could take longer for help to arrive should it be required. This issue was not evident on the departmental risk register.
- Directorate governance reports were completed on a quarterly basis and included details of incidents such as the frequency and nature of incidents for each area of the directorate, how many were awaiting investigation, the top three risks and outstanding actions with deadlines following investigation.
- Monthly departmental meetings took place. These meetings were attended by a range of staff such as consultants and ED managers. Topics for discussion included performance, staffing, staff training, pathway developments and risks and successes.

Leadership of service

- Staff described feeling well supported by leaders. More senior staff described feeling able to support junior staff as well.
- Junior doctors told us that they felt supported when working in the ED and that there was a structure and clear hierarchy in place. However in 2015 the General Medical Council reported that trainee doctors did not feel they were given enough experience, or access to educational resources, or that they were given enough support.

- Staff working in the ED told us that trust executives were visible in the department. For example, they described being visited by a trust executive at 11pm one Saturday night who thanked them for their hard work on what had been a very busy day.

Culture within the service

- Staff described feeling part of a 'good, strong team' with excellent relations between disciplines. Senior staff told us they felt well supported which in turn enabled them to support more junior members of staff.
- There was a sense of pride amongst staff about care provided by the team.

Public engagement

- The trust was keen to source the opinions of patients and those close to them. This was done by distributing questionnaires to people in different formats (postcards, or telephone).
- The trust asked patients to rate their experience of the ED IN the NHS Friends and Family test. In December 2015, 18% of patients responded to the test, of which, 85% stated that they would be likely, or extremely likely to recommend services to friends and family.
- The trust website and posters displayed in public places were used to remind the public about the purpose of the ED – to treat serious and life threatening situations.

Staff engagement

- Managers engaged with staff via meetings each month. Managers described issues with attendance at meetings and so, from January 2016 incentives were used to promote them. These included organising a social event to take place after meetings and challenging each team to organise one meeting each month. Minutes of meetings were completed which showed a range of topics were discussed such as staffing, progress with building works, reminders about documentation and trust incentives to reduce pressure on the ED.
- Senior staff visited the department each month, held listening events that staff could attend, and published a monthly divisional newsletter.
- There was a student and a staff noticeboard for anyone working in the ED. The noticeboard contained contact numbers for student information and practice educators based within the trust and details of incidents, complaints and link nurse details.
- Documents called 'patient safety one liners' were used to engage with staff about patient safety. They included information about incidents, reminders about minimising risk and reassurance about how to speak out if staff had concerns about care.

Innovation, improvement and sustainability

- We saw evidence that staff explored options for future care with innovative ideas. For example, exploring ways of limiting delays and improving the four hour target for admission, treatment, transfer or discharge. One innovative idea centred about those patients ready for discharge but waiting for a package of care to start. Discussions took place about the possibility of healthcare assistants travelling home with these patients to provide care until social care staff were able to take over.
- Staff worked hard to try to cope with increasing numbers of patients coming to the ED. Ideas were trialled which included displaying patient's early warning scores on a screen to enable staff to prioritise patients, researching the sensitivity of initial troponin tests (a test to measure the level of proteins which are released when the heart has been damaged) coupled with further assessments.
- Improvement was measured through the trust ward accreditation scheme. The scheme involved assessing elements of the ED such as documentation, staff knowledge, the environment and staffing before rating it as gold, silver or bronze. The ED was accredited bronze status in January 2016. Areas for improvement were identified such as hand hygiene and daily resuscitation checks.

Medical care (including older people's care)

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

Information about the service

We visited Wythenshawe hospital as part of our announced inspection between the 26 and 29 January 2016.

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

During the inspection we visited wards F12 (endocrinology/diabetes), F14 (complex care medicine), F15 (stroke), F5 (cardiology), F4 (care of the elderly), F7 (care of the elderly), A9 (Gastroenterology), acute medical unit (AMU), acute medical receiving unit (AMRU) and the discharge lounge.

We reviewed the environment and staffing level and looked at 15 care records and 15 prescription charts.

We spoke with 17 patients and seven relatives. We also spoke with staff of various grades including nurses, ward managers, doctors, health care workers and senior managers responsible for medical services.

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

Summary of findings

We gave medical services at Wythenshawe hospital an overall rating of requires improvement. This is because we found concerns in relation to safety due to nurse staffing numbers, the storage of records, the completion of risk assessments, and responsiveness of the service due to bed occupancy.

Nurse staffing levels across the medical wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours, or bank and agency workers. Staff were regularly moved to cover other wards leaving their own ward short of staff. All staff we spoke with reported concerns about staffing levels across medical services. All managers reported staffing levels to be a risk and it was on the divisional risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment and rotas planned well in advance by ward managers and using health care staff to increase the amount of staff on the wards. However, this could potentially lead to a risk of an imbalance of skill mix, and did not mitigate the need for trained nurses to be on shift to provide the care and treatment required.

There were ligature risks in patient bathroom facilities. At the time of inspection these risks were not assessed in order to protect patients who were at risk of harming themselves.

Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients

Medical care (including older people's care)

throughout the hospital due to the demand for medical services. Between January 2015 and December 2015, bed occupancy rates across medical services were over 100%, ranging from 101% to 104%. This meant that there were more patients needing medical beds than actually available. Due to the shortage of beds in medical services, patients were being treated on wards not best suited to their needs (also known as outliers). The trust ensured that all outliers were seen by a consultant, and each ward had a named consultant to carry out this role on a daily basis.

The service used national guidelines and evidence based practice in providing treatment and developing pathways and audits. Audits were completed on both a local and national basis. There were action plans in place to drive improvement, where needed. However, not all risk assessments had been completed in line with the National Institute for Health and Care Excellence (NICE) guidance. Data provided by the trust showed that not all medical wards had met the trust target in compliance with completing Venous Thromboembolism (VTE) assessments throughout 2015.

Records were completed appropriately and we were able to follow and track patient care and treatment easily. However, not all records were kept in locked trolleys or in a locked room to ensure confidentiality.

Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as moving and handling, fire safety, conflict resolution and dementia awareness. At the time of our inspection the trust reported 89% of medical services staff had completed their mandatory training. However, mandatory training was not up to date for all doctors across medical wards.

Major incident planning took place, however we found that plans had not cascaded down to staff across medical wards.

Incidents were well reported by staff, and they had a system in place to safeguard vulnerable people.

Medicines were stored and handled appropriately, and regularly checked to ensure compliance with medicine safety.

The wards we visited were visibly clean, and regular auditing took place to ensure the environment was clean and safe for patients. Infection rates were monitored and displayed on all wards we visited.

Patients spoke positively about their care and treatment. They were treated with dignity and respect. Data for patient satisfaction surveys showed most patients were positive about recommending the department to friends and family. Patients and those close to them were supported with their emotional needs.

There was a focus on discharge planning for patients on all wards we visited. Staff discussed discharges at daily board rounds and bed management meetings. The board rounds provided staff with an overview of the care and treatment for each patient and arrangements required to safely discharge a patient. Once patients were discharged, discharge summaries were provided to patients and sent to their general practitioner.

Senior management understood the need to improve staffing and flow through the hospital to provide safe care and treatment for patients. A robust recruitment plan was in place that included overseas recruitment and many initiatives had been commissioned to improve patient flow and occupancy rates.

The senior team were visible and accessible and well known to the staff. Staff felt the managers were approachable and supportive.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Nursing staffing levels across all wards was variable. All the wards visited during the inspection had numerous vacancies for both nursing staff and health care workers. Medical wards had a high rate of turnover and although sickness levels were not generally high it placed extra demands on the staff and required them to move wards regularly to cover shortfalls in staffing numbers. The managers had increased the number of bank health care workers to help cover wards. However, this risked patients not receiving the appropriate care due to the skill mix of staff.

Information with regards to harm free care was collected by the wards. However, data provided by the trust showed that wards had not consistently completed Venous Thromboembolism (VTE) assessments throughout 2015. This information is collected as part of the NHS safety thermometer, which is a national improvement tool for measuring and analysing avoidable harm to patients and harm free care.

Patient records were paper based and stored on the wards. We found that, on most wards we visited, records were not stored securely. On the acute medical unit (AMU) records were kept on the ward in unlockable trolleys. However we were informed that lockable trolleys had been ordered to keep records secure. Other wards we visited stored records in unlocked rooms off the main ward. For example ward F4 stored records in a room that could not be locked.

There were ligature risks in patient bathroom facilities. At the time of inspection, there was no risk assessment completed in order to protect patients who were at risk of harming themselves.

Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as moving and handling, fire safety, conflict resolution and dementia awareness. At the time of our inspection the trust reported 89% of all medical services staff had completed their mandatory training. However, although nursing staff mandatory training generally met the trust target of 85%, the compliance for medical staff was not up to date for all doctors across medical wards.

The trust had a specific major incident process and plan in place in the event of a major incident being declared. However staff and managers we spoke to were unclear of major incident planning and their role in the case of an emergency.

Incidents were reported by staff through an electronic reporting system, and lessons were learnt and improvements made through investigations. There were systems in place to keep people safe, and staff were aware of how to ensure patients were safeguarded from abuse.

The wards we inspected were visibly clean and well maintained. All staff we spoke to were aware of current infection prevention and control guidelines. There were good processes in place for infection prevention, including regular infection prevention and hand hygiene audits and good monitoring of hospital acquired infections. Subsequent actions were taken to improve performance.

There were systems in place for the safe storage and handling of medicines, and regular checks were completed to ensure compliance.

Incidents

- Incidents were recorded and documented using an electronic incident reporting system to capture data on incidents or near misses. Staff could clearly demonstrate how to use the system, and identified the types of incidents that should be recorded and understood what constituted an incident. Examples given included patient falls, development of pressure sores or insufficient staffing levels on the ward.
- Staff told us they were encouraged to report incidents to protect patients. Feedback from incidents was regularly fed back to the staff via team briefings and staff safety huddles.
- Once incidents were reported a root cause analysis was undertaken and feedback given with any actions for learning. If a medication error was made by the nursing

staff, they were required to complete reflective practice to ensure mistakes were not repeated. Staff reported this highlighted opportunities for learning and retraining to ensure the safe administration of medication.

- There had been a significant number of incidents relating to violence and aggression to staff from patients across the medical division and subsequent action plans were in place. The action plans included resilience training and appropriate support mechanisms had been put in place. Staff we spoke with were aware of counselling services available following incidents of violence and aggression. In the 2014 NHS staff survey 13.75% of staff reported that they had experienced physical violence from patients, relatives or the public in the last 12 months. This score was similar to other trusts.
- From October 2014 to September 2015, medical services had reported no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between October 2014 and September 2015, medical services had reported 27 serious incidents. Information provided by the trust showed that slips trips and falls were the most commonly occurring serious incident followed by pressure ulcers. Managers reported that root cause analysis was completed to establish cause and lessons learnt cascaded to staff. A falls action group had also been commissioned to ensure good practice and share learning to avoid preventable falls.
- Medical services reported 5668 incidents between November 2014 and October 2015. We reviewed the incidents reported, and saw that incidents were recorded and outcomes fed back to the wards. Following incidents of pressure sores on a medical ward, staff were able to explain that they now use a symbol of an owl above patient's beds as an extra reminder that those patients required hourly turns for pressure redistribution.
- Information about incidents was discussed in clinical governance meetings on a monthly basis. The information was also recorded as part of the medicine performance dashboards. The dashboards measured performance of the service on a monthly basis, and reported to the trust board.
- Staff at all levels we spoke to were aware of the duty of candour legislation, and were able to give us examples of when this had been implemented. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services, and inform them and apologise to them when things go wrong with their care and treatment.
- Mortality and morbidity reviews were held as part of the directorate and divisional meetings. The trust reported that they had reviewed very death since 2013 and held a monthly mortality review group to discuss mortality, and review findings.

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 including falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was collected and performance monitored on a monthly basis.
- Safety thermometer information was prominently displayed on all of the medical wards and the results related to that particular ward. All staff we spoke with were aware of the NHS safety thermometer and actions were taken to reduce the likelihood of harm to patients.
- Between September 2014 and September 2015, the trust reported 120 pressure ulcers, 32 falls with harm and 18 CAUTI's. The medicine division reported 52 pressure ulcers, 18 falls and nine CAUTI's.
- Trust data showed not all specialities within the medical division had achieved the trust target of 95% for assessing patients on admission for Venous Thromboembolism (VTE). For example, Endocrinology in November 2015 reported 75% and in December 2015, 83% of patients were assessed for VTE on admission. Elderly care reported 87% and 50% in November 2015 and December 2015.This was against NICE guidance which identifies that patients should expect to have their risk of VTE and bleeding assessed when admitted to hospital using the clinical risk assessment criteria. However, at the time of inspection all the records we checked had VTE assessments completed.

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well maintained. All staff we spoke with were aware of, and adhered to, current infection prevention and control

guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.

- Wards used 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned. However we found on two wards, items that were not clean. On the acute medical receiving unit (AMRU) a set of scales were visibly dirty and on ward F15 we found a dirty handrail.
- There were sufficient hand washing sinks and hand gels. Hand towels and soap dispensers were adequately stocked.
- Hand hygiene audits were completed in line with the world health organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. All wards we visited were compliant in hand hygiene.
- Between October 2014 and October 2015, the trust reported a total of two cases of Meticillin-Resistant Staphylococcus Aureus (MRSA), 47 cases of Clostridium difficile and 34 cases of Meticillin-Sensitive Staphylococcus Aureus (MSSA). Across medicine in December 2015, there were no reported cases of MRSA, and no reported cases of Clostridium difficile compared to three cases in November 2015. In December 2015, there were two cases of Escherichia coli (E-coli), compared with no cases in November 2015, and one case of MSSA in December 2015 compared with no cases in November 2015.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk. There was clear signage on each room, so staff and visitors would be aware of the increased precautions they must take when entering and leaving the room. We observed staff adhering to the necessary precautions to minimise the risk of cross infection.
- Curtains appeared to be clean. However, there was no indication that they had been changed. We were informed by managers that the curtains are cleaned on a rolling programme. If the curtains became soiled then they would be changed immediately. The curtains on the wards we inspected were visibly clean and free from staining.
- Cleaning schedules had been completed and cleaning materials were securely locked away.
- Audits of the environment were completed monthly as part of infection prevention control (IPC) audit. These were completed by ward staff. The results were collected across medicine with actions needed to fully comply with infection control. Senior managers also carried out inspections to ensure that the wards remained clean and free from infection.
- We checked the monthly summary for four wards in October 2015 and found them to be 100% compliant with hand washing and hand hygiene. The monthly summary also showed that F12 scored 98.9% in cleanliness of the environment due to dust being found under a bed and a hand basin was dirty. Actions were logged and the areas cleaned to ensure 100% compliance.
- Patients we spoke with on the ward reported that they were happy with the overall cleanliness of the wards and reported that staff always washed their hands before any care or treatment was given.

Environment and equipment

- Due to the fact that there had been two suicides of inpatients we reviewed potential risk areas and found for example, long pull cords next to hand rails and coat hooks that could potentially be used as ligature points. We saw no evidence of completed risk assessments to protect those patients who were at risk of harming themselves.
- An intercom system was in operation outside each of the wards to maintain the security of patients.
- All areas we inspected were bright and well organised and laid out to enable staff to observe the patients.
- Each ward had its own resuscitation equipment. There were systems in place to ensure the equipment was checked on a regular basis. Records indicated that daily checks were being carried out on the wards we visited.
- There were systems in place to maintain and service equipment. The wards we visited reported that they had no broken equipment. All equipment we inspected was in good working order and well serviced. Electrical items were portable appliance tested (PAT).
- On ward F14 the floor covering had started to split which was a potential trip hazard. It was reported that the trust was aware of the issue, but it was not clear when this work would be completed.

Medicines

Medical care (including older people's care)

- All wards inspected had safe storage facilities for medicines, and had a system for handling and disposing of medicines. All ward staff reported that pharmacists visited the wards daily and the acute medical unit (AMU) had its own dispensary.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked and signed dosages. The AMU had introduced a no talking policy whilst checking and signing for controlled drugs and one signature had to be a senior nurse to minimise the risk of error. Regular checks of controlled drugs balances were recorded.
- All medicines that required storage below eight degrees centigrade were appropriately stored in fridges. Fridge temperatures were regularly checked by staff on the ward.
- All medicines on the wards we visited were in date and there were good stock management systems in place to ensure stock was rotated.
- From January to December 2015 there had been a total of 531 drug errors reported in medical services on the hospital incident reporting system. Of these, 404 were resulted in no harm to patients. The primary cause of medication errors were due to drug administration errors such as medicines omitted unintentionally. Following a drug error, staff were required to complete a reflective practice to avoid a repeat occurrence. Monthly monitoring of medicines was completed by the ward to ensure compliance with the trust policy and extra training provided if necessary. All errors had been investigated and appropriate action taken.
- We inspected medicine prescription records for 15 patients and found that these records were accurately completed with signatures, allergies noted, and legible writing.
- Wards we visited had a pharmacist to support with patients medication. Pharmacists covered the wards between Monday and Friday. The pharmacy was open over seven days and there was an on call pharmacist if required.
- The pharmacy department were present on each ward we visited. They had a process of triaging patients dependent on their level of need. Patients were categorised into three levels. Level one were patients that did not have any high risk medication through to level three which were patients who had multiple high risk medication. By using this system pharmacy were able to ensure patients had access to the appropriate seniority of pharmacist. We observed from the smart board information on each ward we visited, each patient was assigned a level, and pharmacy staff we spoke with were clear on how this was used.

Records

- Patient records included a range of risk assessments, care and treatment plans that were completed on admission and reviewed and added to throughout a patient's stay.
- Records were paper based and stored on the wards. However, on the majority of wards inspected we found records were not stored securely. On AMU records were kept on the ward in unlocked trolleys, which potentially risked that patient records could be accessed by unauthorised people. We were informed that lockable trolleys had been ordered to keep the records secure. Other wards we visited stored the records in unlocked rooms off the main ward. For example ward F4 stored records in a room that did not have a lock.
- We inspected records of 15 patients and observed that recent entries were legible, signed and dated. All records had individualised care plans and assessments had been completed appropriately.
- A clinical documentation audit for the medical wards was undertaken in October 2015, which scored the medicine, red, amber or green in documentation compliance. Red being the worst score (noncompliant) and green being the best (compliant). The medicine division scored green (compliant).Ward managers also carried out a weekly nursing review that ensured records were kept up to date.
- We were informed that the trust was in the process of moving to a new electronic system in the 18 months following our inspection and so the paperwork that was being used at the time of the inspection was being changed to inform the development of the new electronic system to improve patient assessment and planning of care.

Safeguarding

- Safeguarding policies and procedures were in place, and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team which staff reported was a valuable resource as they also offered advice and guidance if

needed. Staff reported that guidance was also available on the trust intranet. Senior nurses and a safeguarding lead nurse were also available to give advice and guidance if required.

- From April 2014 to April 2015 the trust reported 516 safeguarding incidents on the hospital electronic reporting system, 400 of which were made in the medicine division. The data showed that the wards were more regularly reporting safeguarding incidents and had seen a steady increase in reporting numbers, as staff we spoke to felt more confident at reporting safeguard concerns and felt they had adequate training and support.
- The Safeguarding Adults Sub Committee was held bi-monthly and was chaired by the Deputy Chief Nurse. Membership included a senior nurse representation from each clinical Division, the medical lead for dementia, Allied Health Professionals and Tissue Viability representation. The Sub-committee co-ordinated the planning, audit, and reporting of safeguarding adults' issues across the trust. The trust had plans to have an executive safeguarding committee that would meet quarterly and be chaired by the chief nurse.
- Staff informed us that they received feedback from safeguarding referrals, and social workers visited the ward to carry out necessary investigations.
- Training statistics provided by the trust for both medical and nursing staff showed that 95% of staff completed level one and 89% had completed level two safeguarding training. This was better than the trust target of 85%.
- An audit in 2015 took place and actions for improvement identified. Between April and December 2015, the trust had a total of 876 safeguarding referrals. This figure included 172 DoLS referrals and 272 leaning disability referrals and 118 domestic abuse referrals.

Mandatory training

- Staff received mandatory training on a rolling annual programme. The mandatory training included areas such as moving and handling, fire safety, conflict resolution and dementia awareness.
- At the time of our inspection the trust reported 89% of staff within the medical division had completed their mandatory training compared to the trust target of 85%. Cardiology wards reported that their overall compliance with mandatory training up to December 2015 which included medical, nursing and non-nursing staff was 88.83%. However consultant mandatory training was 79%, specialist registrar level doctors mandatory training was 38.89% and speciality registrar doctor mandatory training was 29.86%.
- Staff received mandatory training in learning disability awareness. Data supplied by the trust showed that 89% of staff within the medical division had completed this training.
- Staff reported that completing mandatory training modules online was difficult due to staffing difficulties and due to the fact the computer systems were very slow. Staff told us that they were completing some modules at home in their own time.
- Doctors we spoke with reported that they were up to date with their training and felt well supported.

Assessing and responding to patient risk

- An early warning score (EWS) was used to alert staff if a patient's condition was deteriorating. This was a set of observations including temperature, pain score and respiratory rate.
- Early warning scores were regularly checked and assessed. Repeated checks of the early warning scores were documented correctly in all the records we inspected. Patients we spoke with reported that they were checked on regularly with regards to pain control.
- Upon admission to medical wards staff carried out risk assessments to identify patients at risk of harm. Patients had care plans completed to ensure that they received the right level of care. The risk assessments included falls, pressure ulcers, nutrition (malnutrition universal screening tool MUST) and use of bed rails.
- We observed that Intentional observation rounds were completed to meet the needs of each patient dependent on their level of need. These observation rounds helped to ensure that vulnerable patients were provided with regular help and support and ensure early response time to a patients changing condition.
- There were specialist nurses in tissue viability to support staff in grading pressure ulcers and a falls nurse to support with assessing risk of falls to patients. Patients at risk of falls had a discreet leaf symbol on the board above their bed, the symbol was replicated in their notes and on the smart board (electronic board) used to monitor patients journey whilst on the ward.

- Senior nurses completed weekly audits (clinical ward rounds) that included checking patient risk assessments were accurately completed. These formed part of the ward manager's weekly nursing review and was reported to the ward matron.
- From completing pressure ulcer risk assessments, ward F4 recognised the importance of patients receiving pressure redistribution equipment and so had a spare pressure mattress to ensure patients quickly received the correct treatment.
- Patients at risk of harming themselves were protected by having one to one support in order to maintain their safety.

Nursing staffing

- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements. None of the wards we visited during the inspection had an actual staffing level that matched what was planned. We had requested copies of rotas from the trust but they were not provided.
- Nurse staffing establishment levels across all wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. All staff we spoke with reported concerns about staffing levels across medical services. All managers reported staffing levels to be a risk and staffing was on the risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment and ward managers planned rotas well in advance to highlight any shortfalls and alert senior managers. Managers moved staff around the service to fill staffing shortages. Staff reported that this often left them short on their ward once staff were moved.
- The National Institute for Health and Care Excellence (NICE) guidelines for safe staffing for nursing in acute hospitals was used by the trust. Each ward had a planned nurse staffing rota and any shortfalls in staff numbers were reported on a daily basis to senior managers. From reviewing the current rotas we saw that staff shortages were highlighted, senior managers were aware, and plans made to ensure a safe staffing level.
- The average percentage of qualified nursing and unqualified nursing shifts filled during November and December 2015 was variable. The staff fill rate data supplied from the trust which showed the planned verses actual levels of staff on the wards, identified that generally shifts were being covered by the correct number of nursing and non-nursing staff during the day. However, late shifts and night shifts were not always covered with the correct numbers of qualified nursing staff. To ensure the fill rate of staff was as needed, extra healthcare support workers were used to ensure there was enough staff on the ward. For example, ward F12 and F10 in November and December 2015 did not have enough nursing staff to cover all the planned late and night shifts. However, there were more healthcare workers than planned to ensure there were enough staff to provide care to patients.
- Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across medical services. Managers informed us that, to ensure patient safety, extra bank health care workers were used to fill the shortfalls and provide assistance to the nursing staff. However, this could risk an imbalance of skill mix and did not mitigate the need for trained nurses to be on shift to provide the care and treatment needed to poorly patients. Senior managers informed us that covering of shifts was difficult to plan, and often meant they had very short notice in covering shifts especially evenings and over the weekend. The safer staffing report for December 2015, reported that on F15 there were times that there were three trained staff on nights but one trained nurse could be moved leaving only two trained staff to 22 patients. The report also stated that staff were increasingly reluctant to fill night shifts due to being moved to fill shortfalls on other wards. Staff informed us that being asked to move wards was a regular occurrence. Managers also reported that there were occasions on ward F7 that there had been two trained staff to care and treat 28 patients.
- We reviewed incident reports provided by the trust that related to staffing for the period of September to October 2015, and found that staff on ward F7 reported incidents where there were shortfalls in staffing numbers. In this period there were three occasions where staff reported that there was one trained staff to care and treat 16 patients at night, three occasions where there were two trained staff to care and treat 28 patients at night, one occasion where there was one trained staff to 12 patients during the day, and one

occasion at 7pm where there was only one trained staff on the ward. All wards we visited had submitted incident reports due to low staffing numbers on the wards.

- Senior staff were unclear of the extent of how many vacancies there were across medical services, and reported it was approximately 85 nurse vacancies. Information supplied from the trust showed that from July 2015 to September 2015 medical services excluding cardiology had an average of 78 staff nurse (band five) vacancies from a total establishment of approximately 300 staff nurses.
- Managers told us that they were having difficulty in providing the correct expected staffing levels on medical wards due to a high level of staff nurse vacancies, and due to a staff turnover rate of approximately 17% and a sickness rate of 4.6%.
- We spoke to patients on the ward and some expressed that staff shortages were more evident at night. Managers we spoke to confirmed that it was more difficult to fill nursing shifts at night.
- Safety huddles between ward staff took place twice daily at handover. These huddles provided vital information to staff to ensure patients remained safe. The huddles discussed patient conditions, any safeguarding concerns, falls, pressure ulcer care, incidents and any important information about the ward.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and medical inpatients across the medical wards. All medical trainees contributed to the rota. The information we reviewed showed that medical staffing was appropriate at the time of inspection. Consultant working hours varied between wards. Consultant cover was from 8am to 6.30pm Monday to Friday and included weekend working.
- Senior managers reported that the number of vacancies in medical services was minimal, requiring one speciality doctor in respiratory, two locums in the acute medical unit, one middle grade doctor and one consultant. Generally doctors reported that medical cover across medical services was sufficient. However some doctors reported that if doctors were off or on call it could be difficult to cover shifts.
- On AMU patients were reviewed twice a day by acute consultants to ensure their needs were being met. Throughout medical services there was cover from consultants on a daily basis to review patients, and there was an on call rota which ensured that there was a consultant available 24 hours a day seven days a week.
- The percentage of consultants working in medical services was 36% which was better than the England average of 34%. The percentage of registrars was 45% which was better than the England average of 39%. The percentage of middle grade doctors and junior doctors was 3% and 16% respectively which was worse than the England average of 6% and 22%.
- The trust reported that the turnover rate of medical staff in medical services including cardiology was 22.38%.
- Between November and December 2015 the total number of shifts covered by locum medical staff, excluding consultants was low at 8% for medicine wards and 2% on cardiology wards. There were no locums used to cover consultants on either medical wards or cardiology wards in the same period.
- We observed a ward round which was attended by a consultant, junior doctors and nurses and there was good communication between the multidisciplinary team and the patients.

Major incident awareness and training

- The trust had plans in place to ensure continuity of service during a period of severe winter weather. A trust plan had been drawn up with roles and responsibilities. This included a reminder for staff to encourage them to have their flu jab.
- In the event of staff shortages a staffing escalation plan detailed the responsibilities of the managers to ensure that staff shifts were covered on a daily basis to ensure patient safety.
- The trust had a specific major incident process and plan in place in the event of a major incident being declared. The trust held contact numbers and call in details of nursing staff in the event of a major incident which were reviewed on a six monthly basis.
- Emergency Preparedness, Resilience and Response (EPRR) Assurance 2015/16 plan set out the readiness of the trust in the event of major incidents such as interruption of utilities, telecommunication failure, outbreak of disease and widespread interruption to the supply of staff. Nursing staff and managers we spoke

with during the inspection were unclear of major incident planning and their role in the case of an emergency. However, staff were aware of actions they would take in the event of a fire.

Are medical care services effective?

Good

Care plans we saw were person centred and individualised to their needs and contained the necessary information to ensure that patients were provided with safe care and treatment.

Pain relief was managed on an individual basis and was regularly monitored. Generally patients we spoke to said that they were given regular pain relief.

There was evidence of providing services seven days per week. Most staff said that they were well supported by managers and had access to specialist nurses for advice and guidance if needed.

Multi-disciplinary team working was established on the medical wards. We saw that on the wards we visited, nursing staff worked alongside therapy teams to provide care and treatment to patients.

Staff we spoke to knew about the key principles of the mental capacity act (MCA) 2005 and how these applied to patient care. Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). Staff reported that help and guidance was always available and the trust had also provided pocket books and leaflets to support staff.

Medical services participated in clinical audits through the advancing quality programme. However, had ceased to submit data for the medical services programmes in March 2014. Following the inspection the trust told us that they had formally withdrawn from the advancing quality programme from March 2015.

Evidence-based care and treatment

- The service used national and best practice guidelines to care and treat patients. The trust monitored compliance with the National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified. We saw examples of NICE guidance being followed for intravenous fluids (IV) and acute kidney injury (AKI). The service had an advanced nurse practitioner who had 11 years' experience and a nurse recently appointed to complete AKI audits.
- Care plans we saw were person centred and individualised to their needs and contained the necessary information to ensure that the patients were not at risk.
- There were specialist nurses available on the medical wards that were able to provide advice and guidance on a variety of topics, such as dementia, diabetes, and heart failure.
- The service participated in clinical audits through the advancing quality programme. Advancing Quality (AQ) was an NHS quality improvement programme which aimed to improve the standards of care patients received while in hospital. Its aim was to give patients a better experience of health services and, ultimately, a better quality of life by making ensuring every patient received the same high standard of care no matter which hospital they attended. The trust had submitted data to six of the 15 programmes which had been available from October 2008. However, medical services had ceased to submit data for the medical services programmes in March 2014. Managers informed us that there had been a failure to report this information to the advancing quality programme. There was no action plan to rectify the reporting of this data to the advancing quality programme. Following the inspection the trust told us that they had formally withdrawn from the AQ programme in March 2015.
- From the audits completed in 2014, data showed that for the heart attack audit, the trust scored 93% to 100% in all but one measure. In the pneumonia audit, the trust scored between 80%-100% in all but one measure. In the stroke audit the trust scored between 80% to 95% in all but one measure, where they scored 51% for being admitted to a stroke ward within four hours of admission. The score was low due to the trust not being a hyper acute centre, so some patients on admission to accident and emergency were transferred to other hospitals for treatment and repatriated once the patient was stable.
- The trust had a programme of local and national audit priorities. These included adult asthma, emergency use of oxygen and inflammatory bowel disease.

Medical care (including older people's care)

- The inflammatory bowel disease (IBD) audit 2014/2015 results found that 95% of patients admitted to medical services were seen by the IBD team compared to a national average of 48%. Additionally 87% had stool cultures sent, compared to a national average of 81%. The audit included action plans to improve future performance.
- There were examples of recent local audits completed on the wards. Audits were completed by senior nurses and the information cascaded down to the ward staff via ward meetings and on notice boards.
- Care pathways were in place for managing patients who needed care following a stroke. Stroke assessors assessed patients on the accident and emergency department to ensure they were seen quickly and their needs assessed so decisions could be made as to the best place of care. Pathways were followed for the frailty patients on AMU. Results from the 2015 audit showed that 100% of patients had their early warning score (EWS) completed within 30 minutes of arrival to the unit which was significantly (better than the standard of 80% of other nationally participating AMU departments.
- There were pathways in place for ambulatory care. Ambulatory care is medical care provided on an outpatient basis. The ambulatory care pathways included deep vein thrombosis (DVT), and chest pain pathway.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Generally patients we spoke to said that they were given regular pain relief. A cognitive pain assessment tool was used to help identify pain in patients who found it difficult to express their needs. Additionally specialist dementia nurses were available to support staff.
- We reviewed patient records and found that patients had their pain score regularly documented.

Nutrition and hydration

- The department used the malnutrition universal screening tool (MUST) as part of an individual patient assessment. This was to help identify patients who may be at risk of malnutrition and to refer them to appropriate professionals for ongoing support. We reviewed patient records for the medical service and found that all patients had their MUST score calculated.
- A coloured red tray scheme was in place to highlight which patients required assistance with eating and drinking and staff at mealtimes were seen to be assisting patients as needed. People who required support with meals were discussed in the morning safety huddle to ensure staff were aware of those identified patients.
- The majority of patients we spoke with said that they were happy with the standard and choice of food available.
- In the 2014 CQC in patient survey, patients scored the trust 7.3 out of 10 for did you get enough help from staff to eat your meals. This was similar to other trusts.

Patient outcomes

- The trust took part in a number of national audits to benchmark their performance against other participating trusts in England. The trust results showed a mixed performance. In some areas they performed better than the England average and worse in others. Action plans were developed to improve future performance.

- The myocardial ischaemia national audit project (MINAP), is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/2014 for this trust showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N STEMI- a type of heart attack that does not benefit from immediate Percutaneous Coronary Intervention (PCI) seen by a cardiologist prior to discharge was 96%, which was better than the England average of 94.3%. The percentage of patients that were referred for, or had angiography was 80.5%. The England average was 77.9%. However, only 26% of patients were admitted to a cardiac ward compared to an England average of 55.6% .The trust told us that all patients that required an angiogram were treated on a cardiac ward.
- The sentinel stroke national audit programme (SSNAP), is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The latest audit results from July to September 2015 rated the trust overall as a grade 'D'. The score was not indicative of the service provided by the trust as they did not operate as a hyper acute centre and instead was a district stroke unit. Changes in 2015 meant that all patients suspected of having a new onset of stroke was taken to a hyper acute stroke centre.

However due to the high numbers of patients seen by the stroke unit, they were not exempt from a number of the key indicators that apply to hyper acute stroke centres.

- The 2012/13 heart failure audit showed the trust performed worse than the England average in all four of the clinical (in hospital) indicators but performed better in five of the seven clinical (discharge) indicators. An action plan had been developed to ensure that if it was not possible for a patient to be admitted to a cardiology ward they would still have input from a heart failure specialist.
- In the 2013 national diabetes inpatient audit (NaDIA), the trust scored better than the England average in 16 out of the 21 indicators.
- The endoscopy decontamination suite had been awarded Joint Advisory Group (JAG) accreditation in March 2015. The accreditation process assessed the unit infrastructure policies, operating procedures and audit arrangements to ensure they met best practice guidelines. The decontamination suite ensured all equipment was cleaned and processed to support safe care to patients undergoing an endoscopic procedure.
- In the National Lung Cancer Audit – Mesothelioma 2015, the trust scored 96% in the number of patients that were discussed at a multi-disciplinary meeting, compared to an average of 95%. The audit report identified areas where care could be improved; in that more patients should be seen by a lung cancer specialist nurse at initial clinic appointments and at time of diagnosis. Actions had been put in place to improve this aspect of the service.
- The average length of stay for elective medical patients between July 2014 and June 2015 was 4.3 days which was worse than the England average of 3.8 days. For non-elective medical patients the average length of stay was 6.9 days which was marginally worse than the England average of 6.8 days. Geriatric medicine performed better than other departments in medicine achieving an average length of stay of 6.9 days compared to an England average of 10 days. The trust provided length of stay performance figures for cardiology up to September 2015 and the length of stay for elective patients was 3.2 days and for emergency patients 5.4 days. Length of stay was discussed in weekly meetings and information cascaded to all managers via performance summaries.
- The readmission rates for medical services from June 2014 to May 2015 were marginally worse than the England average across all areas of medicine for both elective and non-elective patients. A review for reducing readmissions had been undertaken with actions such as ensuring the right patients were being seen in the ambulatory care unit.
- The Summary Hospital Level Mortality Indicator (SHMI) is a set of data indicators used to measure mortality outcomes at trust level nationally using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. In 2014/15, the SHMI value of 96 placed UHSM in the top 30% of trusts nationally. The trust identified actions to reduce mortality through improved clinical coding and had a mortality group board that reviewed every death that occurred at the trust since 2013. The trust reported that they had reviewed 2842 cases.

Competent staff

- Staff told us they received an annual appraisal. Appraisal rates for medical staff varied between medicine disciplines (excluding cardiology) and ranged from 62% to 71% in November 2015. Appraisal rates for nursing staff varied between medicine disciplines (excluding cardiology) and ranged from 58% to 73% in November 2015. Cardiology wards for up to August 2015 had an appraisal rate of 77%. This was worse than the trust target of 85%.
- Staff informed us that there was no trust policy or formal process for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work. However, nursing staff reported that they do have regular meetings with their manager and were able to speak to their manager when needed. Managers reported that they had an open door policy and staff were able to discuss issues at any time.
- We observed senior managers on the ward offering advice and guidance to staff and to ensure processes were followed.

Medical care (including older people's care)

- Staff we spoke with reported that they had an adequate induction and were supernumerary on the ward for four weeks. New starters had an induction pack to help orientate themselves to a new ward and regular meetings to assess abilities and outline training needs.
- Generally, medical staff were very positive about the level of induction, training and support they received. However, one locum doctor reported his induction prior to starting was poor.
- On the acute medical unit there were regular training sessions planned on topics such as pressure sores, falls and early warning scores.
- In the 2014 NHS staff survey 84% of staff reported that they had received job relevant training, learning or development in the last 12 months. This score was better than the England average of 81%.
- Each ward had a number of link nurses, these were nurses trained to offer advice and guidance to other staff in infection control, pressure ulcer care, tissue viability, dementia, pain, learning disabilities and safeguarding. There were also lead nurses available in these areas for support and guidance, if required.
- From September 2015 the health care support workers were required to start completing the 15 care certificate competencies. Each ward had a number of assessors to support the process. The care certificate was knowledge and competency based and set out the learning outcomes and standards of behaviours required for health care workers. Wards we visited had health care workers that had commenced the training and the programme was being rolled out to new starters. Up to December 2015, there were 105 staff trust wide that had commenced the care certificate.

Multidisciplinary working

- Multi-disciplinary team (MDT) working was well established on the medical wards. We saw that, on the wards we visited, nursing staff worked alongside therapy teams to provide care and treatment to patients.
- We observed medical staff, nursing staff, therapy teams and pharmacy discussing patients as part of the board round process. The board round centred around the smart boards which provided information as to what was happening on a daily basis with each patient on the ward.
- Ward teams had access to the full range of allied professionals and team members described good collaborative working practices. There was a joined up approach to assessing the range of people's needs, and these were documented in the patient records so that all team members were kept up to date.
- The trust had good links with the volunteer services and they were present on the wards supporting patients.
- A mental health team, known as the Rapid Assessment Interface Discharge team (RAID), psychiatric nurse liaison, safeguarding team, social services and a discharge team which included district nurse liaison were available within the trust to provide assessments to patients and support to staff. RAID provided support to the trust 24 hours per day over seven days via an on call system to ensure those people with mental health needs were supported.
- The trust had an alcohol liaison team that were available to see patients with alcohol dependency and were able to make referrals to substance misuse teams between Monday and Friday.
- Daily ward meetings, referred to as board rounds were held on wards we visited which were attended by the MDT. These included a review of patient care and treatment, discharge planning arrangements and confirmed actions for those people who had complex factors which may affect their discharge. We observed that these board rounds were well attended by a range of professionals.
- We reviewed MDT working for a patient who had a recent diagnosis of oesophageal cancer, and found that referrals had been made to palliative care and appropriate reviews had taken place.

Seven-day services

- The trust had invested funding to support seven day working which included medical services. Consultants and medical staff were available seven days per week.
- Staff informed us that diagnostic testing, pharmacy and therapy was available seven days a week to ensure continuity for patients.
- The integrated discharge team which was a multiagency approach to planned discharges worked seven days per week. However we were informed that social care services did not provide a full team of staff over a weekend.
- The Endoscopy unit operated from Monday to Friday. However Saturday clinics were being held and in an emergency over the weekend there was a consultant on call.

Medical care (including older people's care)

Access to information

- The wards we visited used a smart board, which was an electronic screen updated by staff with regards to patient name, location on the ward, any risks, discharge information and involvements.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner, including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited that gave staff access to patient and trust information. Policies, protocols and procedures were kept on the trust intranet, and wards had copies in the office. Staff reported that the computer system was very slow and made inputting information time consuming. Updated computers had been installed and a new computer system was planned with the next 18 months.
- Wards we visited displayed information with regards to patient safety, training, and upcoming events. Newsletters with current changes in ward performance and actions were readily available for staff to read.
- On the majority of wards we observed that there were files containing minutes of meetings and protocols available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with knew about the key principles of the mental capacity act (MCA) 2005 and how these applied to patient care.
- Staff reported that MCA training was delivered in mandatory training incorporated into the safeguarding and learning disabilities training. Staff reported help and guidance with regards to MCA and DoLS was available on the trust intranet with simplified templates, and support could be gained through dementia nurses and the safeguarding team. The trust had also supplied pocket guides and there were posters to remind staff of processes. The policy relating to MCA and DoLS had recently been updated in 2015 and a monthly safeguarding committee took place to review any safeguarding concerns.
- From the patient records we observed on medical wards, all records had mental capacity recorded and if bed rails were being used a risk assessment had been included. Bed rails are seen as a form of restraint in the national medical council code of practice. We reviewed patient records and found that appropriate bed rail assessments had been completed.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). DoLS are part of the mental capacity act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interests of the person, and there is no other way to look after them. This includes people who may lack capacity. We saw an example of DoLS paperwork being completed and a hospital incident report completed alongside, to alert the trust that a DoLS was being completed. The staff nurse completing the form was able to explain the process fully and complete the necessary documents.
- In July 2015 a review of the safeguarding services took place and data showed that the number of DoLS referrals had increased. In March 2014 only five referrals were made. In January 2015, 12 referrals were made. In February 2015, there were17 referrals and in March 2015, there were 15 referrals. This showed that staff had an increased awareness and more referrals were being made. Staff we spoke with reported that they felt more confident in making referrals, and there was information to support them on the trust intranet, and the safeguarding team were helpful and accessible.

Are medical care services caring?

Good

Care and treatment was observed to be delivered to patients in an individual caring and compassionate way. Staff treated patients and each other with dignity and respect, and interactions were positive.

Staff had a visible person centred approach to delivering care and worked efficiently to ensure the needs of the patients were being met.

Staff were observed to be introducing themselves to patients upon assessment.

Medical care (including older people's care)

Staff actively involved patients and their relatives in the delivery of care and treatment, and tailored their help to the individual needs of the patient.

Patients had a named nurse on admission and we observed staff spending time with the patients to address their individual needs.

Compassionate care

- Patients were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
- We observed staff being open, friendly and helpful to patients and each other.
- All patients we spoke with reported the overall view of the quality of the service was good, and they were happy with the service received.
- Patients said that staff always introduced themselves before care and treatment took place.
- The NHS friends and family test (FFT) average response rate from August 2014 to July 2015 was 43% which was significantly higher than the England average response rate of 34%. The NHS friends and family test asks patients how likely they are to recommend a hospital after treatment. Ninety six percent of patients said that they would recommend the service.
- In the cancer patient experience survey (CPES) for inpatient stay 2013/14, the trust performed in the top 20% of all trusts in 15 out of the 34 areas surveyed. The trust did not fall in the bottom 20% of trusts in any area of the survey.
- Most patients we spoke to were happy with the treatment they received and reported that they had been involved in their care and treatment.
- In the 2014 CQC survey, patients gave the trust a score of 7.7 out of 10 for were you involved as much as you want to be in decisions about your care and treatment. This score is about the same as other trusts.
- The trust performed similar to other trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- All patients on the wards we visited had a named nurse and consultant. Patients we spoke with were aware of the nurse looking after them.
- Patients said that they had been involved in their care and treatment and were aware of any discharge plans in place. Patients said that they felt safe and the ward was clean.
- Patients who required extra support to make their needs known had a 'this is me' card in their records. This was completed with the patient and those close to them to ensure it expressed their preferences. We observed the card being used on the wards we visited to help meet the needs of patients.
- The wards had dementia champions, who were specially trained to help support the care for patients' living with dementia. These champions acted as a point of contact for the staff on the ward. The dementia champions were part of a trust dementia strategy 2014/17 which was introduced to develop a highly skilled workforce in dementia and ensure that the trust delivered patient centred care that supported people living with dementia.
- Family members we spoke with said they were kept informed; they could visit when they liked and were offered drinks.
- In the 2014 CQC in patient survey, patients gave the trust 8.4 out of 10 when asked, 'when you had important questions to ask a nurse, did you get answers that you could understand?' This score was similar to other trusts.

Emotional support

- We observed staff taking time to talk and listen to patients and provide reassurance and comfort to patients. Staff took time to understand the needs of the patients to enable them to best address their concerns.
- In the 2014 CQC in patient survey, patients gave medical services 7.6 out of 10 when asked 'do you feel you got enough emotional support from hospital staff during your stay?' This score was similar to other trusts.
- Visiting times were flexible and patients and visitors reported they felt visiting times were sufficient.
- The trust had a sage and thyme programme which provided workshops to support staff communication skills to notice distress, hear concerns and respond helpfully to patients in distress. Staff reported this gave them knowledge and confidence in talking through problems with patients.

Are medical care services responsive?

Medical care (including older people's care)

Requires improvement

Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services**.** There were times when bed capacity was insufficient to meet patient demand. This resulted in patients receiving their care and treatment on wards that were not aligned to their needs and outside the staff speciality or competence.

Medical care and treatment was being provided on wards outside the staff speciality, as outlying patients were being cared for on wards that were not suited to their needs or condition.

There were many patients who were medically fit to leave hospital but were unable to, due to other factors including waiting for social care packages and care home placements.

The trust was working with other organisations in the community to develop new models of care. They had commissioned community beds in order to discharge patients to care settings whilst they recuperated from an acute illness, and ambulatory services to avoid hospital admissions.

The trust had implemented a number of schemes to help meet people's individual needs, such as a falling leaf symbol to indicate that a patient was at risk of falls and a forget-me-not sticker for people living with dementia.

People were supported to raise concerns or complaints. Complaints were investigated and lessons learnt were communicated to staff.

Service planning and delivery to meet the needs of local people

- A resilience plan had been developed to ensure the hospital would be able to manage the pressures associated with winter. The plan involved partnership working with other agencies to ensure patients were quickly seen and safely discharged. The plan highlighted the actions and responsibilities to be taken to ensure continuity of services.
- The older person's assessment and liaison service (OPAL) was developed to avoid admissions to hospital of the older population. The trust found that 65% of admissions are of people over 80 years old. The OPAL team, which included consultants and therapy staff, provided an early comprehensive geriatric review to ensure the older population were seen quickly and discharged with increased care if needed, or transferred to a community bed for recuperation, without needing an admission to hospital. It was found that older people once admitted had an increased length of stay due to associated mortality, morbidity, and dependency due to deconditioning associated with an inpatient stay. The OPAL team had found that only 39% of people over 70 needed to be admitted following their assessment and intervention, compared with 66% of patients admitted without their intervention. Data from October 2015 showed they discharged 186 patients and their length of stay was two days compared with a trust average of nine days.
- In order to improve the waiting time for patients attending geriatric outpatient's clinics, the structure of clinics had been changed so patients could be offered an appointment within a week via a rapid access clinic. The rapid access clinics were set up to run daily (Monday to Friday) and accommodated four new and four review patients per clinic. Rapid access clinics for chest pain were available to ensure patients referred were seen quickly and to avoid potential admissions to hospital.
- Medical services had a designated ambulatory care unit. The unit saw patients on an outpatient basis for tests or follow up assessments to avoid unnecessary admissions. GP's were able to refer patients to the unit to avoid accident and emergency admissions. Staff told us the unit saw approximately 25 to 30 patients a day from Monday to Friday.
- We spoke to doctors on the ward we visited, and they were knowledgeable and understood how services at the trust were tailored to meet the needs of the local population.
- The trust had commissioned 35 community beds for people who were medically fit and no longer needed to stay in hospital but were not ready to be discharged home. We were told these beds were funded up to the end of March 2016.

Access and flow

Medical care (including older people's care)

- Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services.
- Between January 2015 and December 2015, bed occupancy rates for medical services were over 100%, ranging from 101% to 104%. This meant there were more patients needing medical beds than they actually had. Evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital. In the 12 months of 2015 no real change to bed occupancy had been achieved even though initiatives for reducing patient length of stay had been implemented.
- The information provided by the trust showed there was a shortage of medical beds and a number of patients placed on wards that were not best suited to their needs (also known as outliers). The trust had a target of 15 outliers per month. However medical services from July 2015 to December 2015 had an average of 21 outliers per day.
- The trust had a policy on outliers being seen and treated on wards, and each ward had a dedicated consultant to review them on a daily basis. We reviewed records of outliers on the gynaecology ward and found they had been reviewed by a consultant. However, this did not ensure that patient day to day care and treatment was being provided by staff that had the required competency as it was outside their speciality. For example medical patients were receiving care and treatment on surgical wards.
- The trust had a patient flow and escalation policy that was being followed and meetings were held several times a day to discuss patient flow and bed availability throughout the hospital. We observed a bed flow meeting and, although well attended, no attendance was provided from the executive team. We were informed that the executive team ordinarily attended and had access to data constantly with regards to the status of beds throughout the trust. Meetings were held with action undertaken to reduce bed occupancy.
- At the time of inspection the cardiology day case ward was being used from 7.30pm to provide bed space for patients. This was being staffed by bank and agency workers from 7.30pm to 7.30am. This meant that if the patients were not transferred or discharged that day or the following morning, there would be no bed space for day case patients. Managers told us that at the time of inspection there were 10 outliers in the short stay unit and if they were not discharged, meant that potentially some of the day case patients would have needed to be cancelled. Managers informed us that this had caused some cancellations to seeing day case patients.
- The average length of stay for patients on medical wards was marginally worse for elective and non-elective patients than for the trust as a whole, with a rolling 12 month average length of stay up to December 2015 of 5.08 days for elective patients and 7.4 days for non-elective patients. The trust monitored patients with a length of stay of over 14 days and had an overall monthly target of 180 patients that would have an average length of stay over 14 days. Medical services reported that in October through to December 2015 they had a monthly average of 149 patients with a length of stay above 14 days.
- From July 2015 to December 2015 the trust had 579 patients who were medically fit to leave hospital (also known as delayed discharges) but were unable to leave due various circumstances. The trust reported of these, 267 patients were awaiting care packages in order for them to return home safely. Of these, 242 patients were awaiting completion of an assessment for care, 37 were awaiting nursing home placement, 18 were awaiting residential care, five were awaiting rehabilitation beds and seven were awaiting community equipment. At the time of inspection we were told that there were 90 patients who were medically fit and were still in hospital.
- The trust had a discharge lounge which operated Monday to Friday from 7.00am to 8.00pm and there was a transfer team to help support the flow of patients from wards to the discharge lounge.
- There was a patient flow team (discharge team) consisting of bed managers, discharge facilitators, night managers, and social services to facilitate discharges from hospital.
- From October 2014 to September 2015, 28% of patients moved wards once, 8% moved twice, 3% moved three times and 2% had more than four moves during their hospital stay. The figures provided by the trust did however show a slight downward trend in the number of bed moves a patient had during their stay. These figures also showed that not all patients were being treated on the correct speciality ward for the entire duration of their stay.

Medical care (including older people's care)

- Medical services had a referral to treatment (RTT) target of 92% for all specialities and were generally meeting the target. In October and November 2015 the performance was 97% and 92% and fell marginally below the target in December 2015 at 91%.
- There was a focus on discharge planning for patients on all wards we visited. Staff discussed discharges at daily board rounds and bed management meetings. Once patients were discharged, discharge summaries were provided to patients and sent to their general practitioner.

Meeting people's individual needs

- The trust used a falling leaf symbol to indicate when a patient was at risk of falls. These symbols were placed on the bedside board of the patient, and displayed on the hospital smart board to alert staff of the risk and ensure appropriate care was given. All staff we spoke with were able to explain the symbol's use, and from the smart board, could see at a glance how many patients were at risk of falls.
- Patients said if they used the call bell, nurses attended to their needs promptly, and were checked regularly by staff.
- Chaplaincy services were available to patients and there was accommodation for relatives if needed.
- The trust had implemented the 'forget me not' scheme, where a discreet flower symbol was used as a visual reminder to staff of patients who were living with dementia. This ensured patients received appropriate care, reduced the stress for patients, and increased patient safety. The wards also used a 'forget me not' card completed alongside patients and their families to express their preferences. These were used on the wards we visited and located on the patients' bedsides. We observed patients living with dementia had been identified and the discreet symbols used.
- Some wards had been subtly adapted to be more dementia friendly, paintwork and signage was changed to help support those patients living with dementia.
- The trust used a health passport document for patients with learning disabilities. Patient passports provided information about the person's preferences, medical history, and support needs.
- The 'my health passport 'had been introduced for anyone who was living with a medical condition which required on going care and support. The passport aimed to be a record of how an individual's health was evolving, and provide information to support their health and wellbeing. The document would be updated following medical consultations.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the online service.
- Leaflets were available for patients about services offered through the trust or in the community. Staff knew how to access copies in accessible formats, if needed.
- All care was delivered in side rooms or in bays. There were no mixed sex concerns in any bays we inspected and the trust reported had no mixed sex breaches during 2015.
- There were translation services available for patients, if required, and staff we spoke with knew how to access the service.

Learning from complaints and concerns

- Patients and those close to them knew how to raise concerns or make a complaint. The trust encouraged people to provide feedback about their care. Leaflets were provided, and there were boxes on the wards for them to be posted.
- There were leaflets available on the wards which explained the complaints procedure and details for the Patient Advice Liaison Service (PALS).
- Staff were aware of the complaints system and how to advise patients and those close to them to make a complaint.
- The medical division received 44 complaints in December 2015, and reported they had all been addressed within the timeframe agreed with the complainant. We saw evidence that the outcome of complaints was discussed in monthly clinical governance meetings and found that open and honest letters were sent to patients and their families.

Are medical care services well-led?

Good

A risk register was in place and monitored regularly with actions and review dates.

Medical care (including older people's care)

The trust had a clear vison and strategy with a clear commitment to quality. The trust vison was to become a top 10 NHS provider in the country. Their mission was to improve the health and quality of life for all patients by building an organisation that attracts, develops and retains great people.

The department was managed by an accessible management team who were visible and well known to the staff. The managers spent time on the ward, providing support and encouragement.

There was a positive culture throughout the service. Staff were very positive about their managers and felt supported to carry out their roles.

Staff felt confident in raising concerns, able to suggest improvements and were proud to work for the trust. Many staff had been in post for many years.

Senior management understood the need to improve staffing, and flow through the hospital to provide safe care and treatment for patients. A robust recruitment plan was in place that included overseas recruitment and many initiatives had been commissioned to improve patient flow and occupancy rates.

There were a range of reward and recognition schemes to recognise the work staff completed in ensuring quality of care and patient safety.

The service actively sought feedback from patients and visitors to help improve the quality of the service.

Vision and strategy for this service

- The trust vison was to become a top 10 NHS provider in the country. Their mission was to improve the health and quality of life for all patients by building an organisation that attracts, develops and retains great people. The trust reported they were a value based organisation with five core 'PEOPLE' values (people first, excellence, one team, open and leadership).
- The trust's objectives were based on this vision and set strategic goals, which were cascaded down to the service and individual objectives for staff. The vision for the trust was displayed around the hospital for patients, visitors and staff.
- Staff we spoke to felt that they were equipped for their role and had clear roles and responsibilities.

Governance, risk management and quality measurement

- The medical division used a risk register to monitor risks, and mitigation actions were recorded with progress and review dates. Items on the register reflected those highlighted by the senior staff.
- The risk register highlighted risks across medical services and actions were in place to address concerns. For example, staffing levels across the service was identified as a risk and a recruitment process was on going to address the issue. On all wards we visited managers were able to explain how many staff they were short and the recruitment process for their area. The risk register also highlighted actions required, such as rotas to be completed at least four weeks in advance, matron staffing huddles to be completed daily, and incentives for recruitment including offering band six promotion after 18 months. We found all these actions were taking place during the inspection.
- Staff at all levels knew there was a risk register for their area and what risks and mitigation action were on it.
- There was a clear governance structure, and meetings were held on a monthly basis to discuss service performance. Monthly performance reports (dashboards) were produced at directorate and divisional level. The service used the performance dashboard to measure key quality indicators in terms of meeting standards. Improvements in performance were ongoing and the managers of the service were clear of the work needed to improve performance.
- The medical division recognised an important element of achieving high quality care was to ensure staff had the capacity and capability to deliver improvement. Staff across the medical division had signed up to be quality champions. The aim was to involve staff to help improve services for patients. On all wards we visited there were a range of staff who were trained as dementia champions.
- Senior staff undertook regular care and quality assessments across all the wards to highlight any areas of concern so immediate action could be taken to improve care and quality for patients. We saw evidence that environmental audits and records audits had been completed.

Leadership of service

Medical care (including older people's care)

- The trust had recently undergone a change in the executive team. An interim chief executive had been appointed a week prior to the inspection to provide a clear direction and leadership for the trust.
- Staff reported that there was very clear leadership from managers of all levels. Most could name executive board members and reported they visited the wards, but would like more visibility to provide positive encouragement. All staff we spoke with knew of changes in the executive team.
- The senior managers were aware of the actions required to address staffing issues. Recruitment of nursing staff was ongoing, including from overseas. We saw evidence that there was a rolling programme of new nurses starting within the trust, with an initiative scheme to attract nurses by offering promotions within 18 months. Ward Managers were able to confirm that they had appointed new nurses that were due to start imminently.
- Leaders understood the importance of improving the flow through the hospital. Many initiatives had been commissioned to rectify the trust position on bed occupancy. Initiatives such as the OPAL team, commissioning of community beds, rapid clinics, and ambulatory unit provided added flow through the hospital, ensuring patients were seen and treated promptly and discharged to aid flow through the hospital. However, although initiatives were in place the bed occupancy rates had not at the time of inspection changed.
- All nursing staff spoke highly of the ward managers and matrons, and told us that they received good support.
- We observed ward managers and matrons to be visible and supportive on the wards. Interactions were positive and encouraging providing advice and guidance to all staff.
- In the 2014 national staff survey, staff scored being supported by their managers 3.73 out of five. This score was slightly above the score given by other trusts (3.66).
- Doctors told us senior medical staff were accessible and responsive and they received good leadership and support.

Culture within the service

- Staff aligned there working practice in line with the trust values. We saw staff putting people first, they strived to provide an excellent service, and they worked together with managers, being open and honest with their views. We observed the working practice on the ward, and saw that staff worked co-operatively with other professionals and managers to provide the best care and treatment to patients.
- Discharge planning was a well-established culture within the service. We saw on every ward we visited an emphasis on planning discharges for patients through daily board rounds.
- Senior managers attended regular bed meetings to discuss and co-ordinate flow through the hospital and fed back to the wards the current bed position.
- There was a culture of wanting to improve the care and safety for patients on medical wards within the trust. A ward accreditation scheme promoted achieving high standards. Wards were awarded Bronze, silver, gold or platinum for attaining a set of key performance standards. Wards we visited were proud of their awards, and felt it valued the hard work they had done to achieve the award.
- Nursing and medical staff said they felt supported and able to speak up if they had concerns. However, some staff felt after raising a concern nothing changed or not acted upon quickly. For example staff reported concerns with regards to staffing shortages and felt nothing had really changed. Managers we with spoke with gave us positive assurances that the trust was actively recruiting more staff at the time of inspection.
- Staff reported their wellbeing was supported by a range of services, including counselling and personal one to one sessions, if required. Debriefing sessions were held following particular difficult times and resilience training was provided. Staff we spoke with were aware of different support mechanisms, and felt they could raise any issues with their managers. In the 2014 national staff survey 31% of staff reported suffering from work related stress in the previous 12 months. This score was better than the England average of 37%.
- Generally staff reported that working for the trust was 'fantastic' and 'a lovely place to work'.
- In the 2014 national staff survey, 67% of staff agreed that they would feel secure raising concerns about unsafe clinical practice. This score was similar to other trusts (68%).
- In January 2015, the trust launched a new initiative called Speak Out Safely. It was part of a continued commitment to patient and staff safety and wellbeing,

Speak Out Safely brought together a number of existing trust systems, along with a new service, all of which were designed to help staff raise any concerns in a supportive environment.

Public engagement

- Board meeting minutes, papers and annual reports were available online to the public which helped them understand more about the trust and how it was performing.
- Wards displayed how well they performed with regards to infection control and staffing levels.
- The trust participated in the NHS friends and family test, giving people who used services the opportunity to provide feedback about their care and treatment.
- The trust gathered views using social media. One review reported 'my partner loved the staff there in the cardiology dept. So now I am donating a percentage of my revenue in his memory to say thank you.'

Staff engagement

- Most staff felt respected and valued by the trust. There were schemes in place to recognise the good work staff had done. Additionally some wards had their own employee of the month scheme to recognise the work individuals had done. On one ward we visited it was reported that employee of the month was given out on the centre of the ward, and staff applauded which boosted the morale of the team.
- In the 2014 national staff survey, 85% of staff agreed they felt satisfied with the quality of work and patient care they were able to offer, compared to an England average of 78%.
- The trust celebrated the achievements of staff at an annual event. At the last annual event medical services had a number of staff nominated for their work at the trust. The trust had an employee of the month scheme to recognise the hard work of staff.
- Staff participated in the NHS surveys, giving them an opportunity to provide feedback about their thoughts about the trust, and held listening events to gather feedback.
- The trust was ranked in the top 20% of trusts for staff engagement in the NHS Staff Survey 2014.

Innovation, improvement and sustainability

- In the 2014 national staff survey, 73% of staff felt able to contribute towards improvements in work. This score was above the national England average of 69%.
- The trust had a ward accreditation scheme in place which was an assessment framework by which each ward was assessed for the quality of care it was delivering to the patients. Through assessing a series of defined indictors or standards, each ward was able to monitor and take steps to improve care for the patients. The scheme looked at a number of quality indicators including infection control, clinical care, dignity and respect, patient experience, environment and equipment, safeguarding, and leadership and training. Following assessment, wards received a bronze, silver, gold or diamond award. Medical services had one ward (F15) with a diamond award. Staff reported that the scheme was a great tool which promoted a healthy drive to improve standards.
- The trust introduced the Older Persons Assessment and Liaison (OPAL) service onto the AMU in September 2015, which was a multidisciplinary team covering accident and emergency and the acute medical unit. The team consisted of a consultant geriatrician, and a therapy team to minimise the number of admissions to hospital and length of stay for older people.
- The severe asthma nursing team at the trust had in 2015 been shortlisted for a nursing times award. This was for their severe asthma patient education programme, which had been developed over the previous four years to support and educate patients living with asthma.

Surgery

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

Information about the service

We inspected surgical services at the University Hospital of South Manchester NHS Foundation Trust between 26 and 29 January 2016, as part of an announced comprehensive inspection. Surgical services provide a wide range of services to local and regional populations, which include the regional unit for burns and plastics and heart and lung transplants. Services for the local population include vascular surgery, gastrointestinal surgery, colorectal surgery, breast surgery, ear nose and throat surgery and trauma and elective orthopaedics. There are a wide range of procedures carried out including in-patient surgery, day case surgery and minor procedures.

Last year there were 33,000 episodes of care. The majority of these were day cases (44%) with 28% emergency cases and 27% elective care.

Surgical services spanned 14 wards, 17 acute theatres, four cardiac theatres and minor procedures. These services were managed by the scheduled care division and by the clinical support services division, who managed theatres.

We inspected the majority of the 14 wards including, vascular ward, admissions lounge, elective orthopaedics, trauma and orthopaedics, surgical admissions unit, breast services, lung surgery, the transplant unit, acute theatres and minor procedures.

During our inspection we spoke with 20 members of staff including ward clerks, student nurses, newly qualified nurses, therapy staff, junior doctors, consultants, senior consultants, nursing leaders and divisional management. We also spoke with 24 patients and relatives and reviewed 20 medical notes.

Surgery

Summary of findings

We found that the hospital was delivering good surgical services to its patients, but some aspects of these services required improvement.

Staffing levels across surgical services were good, but there was one ward where there were periods of understaffing, which were not always able to be addressed quickly.

These periods of understaffing were compounded by the recent appointment of a number of band 6 nurses who were struggling to lead the ward clinically and organisationally when the band 7 ward manager was not present. We observed that these band 6 nurses could be assigned the role of shift co-ordinator, when the ward was not adequately staffed and they were not able to be supernumerary. When this occurred, we observed a lack of co-ordination and chaos that impacted on the care and safety of patients. When the band 7 was absent there was a lack of clinical leadership on this ward, with little clinical leadership support coming from senior nursing staff within the division.

In addition to the difficulties with nursing leadership, there was incomplete clinical oversight from some consultants who had patients on this ward. The difficulties with nursing and medical oversight created a situation which meant that patient care and treatment was not always safe.

The trust had previously recognised that staffing levels on two wards were too low to be safe at full capacity. The low levels of staffing had been observed to have an impact on patient care, in that these wards had reported high numbers of incidents, one for falls and the second for pressure ulcers.

In response to the difficulties on these wards trust management had acted on advice from nursing leaders and temporarily closed beds on the two wards. This situation had detrimental impact on capacity within surgical beds, which further aggravated trust wide capacity issues and contributed to the high numbers of cancelled operations and failure to meet referral to treatment times. This meant that surgical services were not as responsive as they should be and required improvement.

From December 2015 these wards received substantial extra support and development, which was reflected in the improvements that we found on inspection. We noted that the ward where the incidence of falls had previously been high, had witnessed a reduction in falls, as a result of the measures that had been put in place. Morale had improved and good clinical and managerial leadership was evident. Although the second ward had not witnessed a reduction in pressure ulcers, morale had improved and ward based training sessions were being delivered by clinical leaders. However, when we visited this ward on three occasions, there were low staffing numbers for the dependency of the patients, the ward was chaotic, ward equipment was in front of emergency equipment and call bells were being left unanswered for significant periods of time. In particular, on one shift, we observed that there was no supernumerary shift coordinator, patients with increased nursing needs were left unobserved for unacceptably long periods of time. We were informed by divisional senior nursing staff, that the ward staffing was too low on this shift, but attempts to fill the gap for that particular shift were unsuccessful.

There was a positive culture of incident reporting, with staff understanding the value of reporting incidents in improving patient safety. There was a low incidence of infection on all wards across surgical services. Apart from the two wards mentioned, all wards had safe staffing levels with a skill mix deemed appropriate for patient acuity and dependency levels. Medical records were fully completed and medicines were managed safely.

Surgical services provided effective services to patients. It provided services in line with national guidelines and implemented local policies based on national guidelines. Patient's pain was assessed both pre-operatively and when they arrived on the ward. This pain score was documented and pain relief was administered in a timely fashion. If ward staff required more support when dealing with a patient's pain, they were able to access the trust pain team. There were good relationships between the pain team and surgical wards, with the pain team visiting some wards on a daily basis.

Surgery

We observed that surgical services were caring towards patients, interacting with patients in a kind and respectful way. We were able to speak to a number of patients and relatives who stated that all staff were caring and involved them in discussions and decisions about their care.

There were some challenges with access and flow through surgical services; however services were responsive to individual needs of patients. We observed numerous examples where staff adapted services to the needs of patients, including delivering medication through sign language to a deaf patient. The service had considered the changing needs of its population and had trained staff to be ward leaders in care for people with dementia.

Surgical services were good in the well-led domain. The management of surgical services was focused on patient safety and ensuring high standards of care and treatment were provided to patients. Managers and clinical leaders were aware of the issues facing services, such as the ward staffing difficulties and the problems with access and flow through surgical services. They had addressed these problems and developed plans to reduce them. However, at the time of inspection the problems were still evident and impacting on patient care. Managers were not fully aware, however, of the reasons why care had not improved on a ward with difficulties. They had not fully identified the extent to which difficulties with clinical leadership continued to impact on patient care and limit the improvement in care.

Staff morale across surgical services was, in most cases, very high across all professional groups. Directorate medical directors were focussed on new Manchester wide initiatives. Trust management was visible and staff spoke very highly of senior nursing leaders, believing them to be approachable and interested in ward staff.

Are surgery services safe?

Requires improvement

Staffing levels across surgical services were good apart from one ward, where there were periods of understaffing, which were not always able to be addressed quickly. These periods of understaffing were compounded by recently appointed band 6 staff being assigned clinical leadership roles, which they were struggling to fulfil to the required competency, when the band 7 ward manager was absent. We observed the ward when newly appointed band 6 staff were assigned the shift co-ordinator role and the ward was not adequately staffed. When this occurred, we observed a lack of co-ordination and chaos that impacted on the care and safety of patients. When the band 7 was absent there was a lack of clinical leadership on this ward, with little clinical leadership support coming from senior nursing staff within the division.

In addition to the difficulties with nursing leadership, there was incomplete clinical oversight from some consultants who had patients on this ward. The difficulties with nursing and medical oversight created a situation which meant that patient care and treatment was not always safe.

Never events and serious incidents were fully investigated using a root cause analysis (RCA) approach. However, on examining the never events and serious incidents, although comprehensive action plans were developed there was similarity between a small number of cases. This indicated that necessary improvements were not always made and that learning was not always cascaded and embedded into the service.

Staff received training in levels one and two, safeguarding adults and children. However staff did not receive safeguarding children level three training despite 16 and 17 year olds being routinely admitted to surgical wards.

There was a positive culture of incident reporting across surgical services and staff understood the value that reporting incidents had for improvements in patient safety. Surgical areas were visibly clean, equipment was clean and serviced and infection rates were low. There were robust systems in place to monitor risk to patients. Records and medicines management was good. Staffing in most areas was good and skill mix was appropriate. Regular review of

staffing establishment was undertaken using a trust developed tool and staffing levels were reviewed on daily basis by matrons. Senior ward staff felt well supported by matrons and divisional nurse leaders to raise staffing issues or safety risks.

Incidents

- There were five never events reported by surgical services from October 2014 to October 2015. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Three of these never events related to wrong site surgery, one involved a retained swab and another biopsy taken from wrong side of body.
- The trust investigated each of these events, using a root cause analysis approach (RCA) and prepared action plans to prevent any further occurrence of this type. We were able to look at the RCAs for these never events prior to inspection. There was no identifiable link between these never events, however, when reviewing RCA for other incidents, the trust had identified that the World Health Organisation (WHO) safer surgery checklist did not identify all relevant matters that should be identified.
- Nineteen Serious Incidents were reported on STEIS between November 2014 and October 2015. Nine of these serious and reportable incidents related to pressure ulcers.
- We found that all incidents were reported on a trust wide electronic reporting system. There was an incident reporting policy and procedure in place. All staff that we spoke to felt confident reporting incidents and viewed the procedure as an essential patient safety tool.
- A robust incident reporting culture was evident throughout surgical services. From January 2014 to October 2015 almost 4,000 incidents were recorded by staff. The majority of these incidents resulted in minimal or no harm to patients, with 44 classified as resulting in moderate harm or above. The main categories of these incidents causing moderate harm or above were, falls, tissue viability and treatment related matters, such as failure to respond to the medically deteriorating patient. In general, the occurrences of more serious categories of incidents were evenly dispersed throughout surgical services
- However, the vascular ward (A1) and trauma and orthopaedic ward (A5) had noticeably more incidents causing moderate harm and above to patients. The vascular ward had high numbers of tissue viability related incidents and the trauma and orthopaedics ward had high numbers of falls related incidents. Prior to inspection the trust had identified this disparity and investigated the higher number of serious incidents on these wards.
- At the time of our inspection, the trust had taken action to address the high number of incidents on these wards. Staffing levels were reviewed and identified as too low. On advice from nursing leadership, the trust had closed beds on these wards.
- On ward A5, the high incidence of falls was addressed by closing four beds, temporarily and increasing nurse training for falls assessment. The ward had implemented a regular audit for completion of falls risk assessment documentation. The number of falls had reduced since these actions were taken.
- On ward A1, the high incidence of pressure ulcers was addressed in a number of ways; eight beds were temporarily closed to ensure safer staffing levels, a band six vascular specialist nurse had been recruited but had not yet commenced in post. In addition ward based training sessions are being held. At the time of inspection there was no decrease in numbers of pressure ulcers.
- Incident reports identified a lack of nursing staff as a contributory factor causing pressure ulcers on this ward.
- On inspection, we reviewed the standard of documentation for tissue viability assessments and found that all necessary documentation was completed in full.
- The trust continued to identify this ward as requiring support because of the high levels of pressure ulcer which occurred on it and were concerned about the continued high level of pressure ulcers.
- We looked at the root cause analysis (RCA) investigations and action plans for seven incidents that were recorded as moderate harm and above. The investigations were detailed and transparent. Action plans to address the issues identified by the RCAs were also detailed and addressed relevant issues. However, two incidents although quite rare, were of the same nature, which indicated that embedded learning from

incidents may not always occur. The RCAs for these incidents identified that on both occasions the WHO safer surgery checklist did not always identify all relevant information.

- Each directorate reviewed mortality and morbidity at their monthly clinical governance meeting and bi-monthly clinical audit meetings. Minutes of these directorate meetings were made available to inspectors. Senior clinicians across all the surgical directorates reported that these meetings were used to support learning and the minutes of the meetings supported this view.
- A review of the seven root cause analysis investigations indicated that surgical services understood their obligations under duty of candour requirements and observed these obligations. Patients and relatives were fully informed of the causes of incidents in all the cases we reviewed.
- Staff we spoke with were aware of the duty of candour legislation and the importance of being open and transparent with patients and families when mistakes were made.

Safety thermometer

- The NHS safety thermometer is a national tool for measuring and monitoring avoidable harm to patients. The areas which are monitored for the NHS safety thermometer are falls, pressure ulcers, catheter acquired urinary infections and venous thromboembolism (VTE) known as blood clots.
- The trust monitored all of these categories of harm for surgical services. Each ward displayed this information in a public place.
- In surgical services between September 2014 and September 2015 there were 50 pressure ulcers that caused moderate harm or above. 10 falls with harm sustained at level three or above and six urinary catheter related urinary tract infections.

Cleanliness, infection control and hygiene

- The trust had robust systems and processes in place to ensure that surgical services maintained acceptable standards of infection control and hygiene practice. The trust developed infection control policies and monitored staff adherence to these policies on a regular basis. Rates of infection were regularly monitored by the trust and reported at directorate and divisional levels.
- Monthly infection control audits were carried out by ward staff, looking at different aspects of infection control. We were provided with the infection control report for the August audit. Surgical services performed well in most aspects of infection control, which included hand hygiene audits, availability of alcohol gel and shared patient equipment. The environment received a score that gave an amber rating. An amber rating was awarded when the audit revealed less than 100% compliance with trust policy.
- We observed staff using personal protective equipment when delivering care to patients and washing their hands between patients.
- Surgical services screened all patients planning to attend the trust for surgery for Meticillin-Resistant Staphylococcus Aureus (MRSA). This was carried out as part of the pre-operative assessment process.
- Information provided by the trust indicated that there was one case of MRSA bacteraemia attributable to surgical services over the past 12 months. There were two cases of Clostridium difficile (C.diff) from April 2015 to July 2015.

Environment and equipment

- We found that there were systems and procedures in place to keep ward areas and theatres clean and equipment well maintained. Most of the ward areas were kept free of clutter. However, we found that one ward, stored significant numbers of ward equipment, outside of single patient rooms. The same ward also had equipment in corridors and in front of resuscitation trolleys. Equipment stored in this way created a hazard for patients using the ward and presented a potential obstacle for the safe movement of patients and equipment in the event of an emergency.
- All equipment we inspected on the ward areas and in theatres was in date, had been serviced and a label stating the next date of service, was prominently displayed.
- Staff in theatres reported that they had access to the required equipment and all relevant surgical packs.
- Resuscitation equipment was checked on a daily basis, in line with trust policy.

Medicines

- There were systems and procedures in place to ensure the safe storage and management of all medicines, including intravenous fluids. All medicines, including intravenous fluids, were securely stored in line with trust policy.
- All ward areas were visited daily by pharmacy staff who checked prescription charts to ensure that medication prescribing followed local and national policies.
- Controlled drugs were stored in a double locked metal cupboard and were checked daily to ensure that all drugs were reconciled correctly.
- Drug fridges were locked and had a working thermometer. We found that all fridges were within the required temperature range. Documentation indicated that there was a system for checking fridge temperature which was adhered to on all wards inspected.
- Patients held their own medication, brought from home, in locked pods by the side of their bed.
- We reviewed eight prescription charts and found them to be legible and completed in full, with prescriptions signed and dated and allergies noted.

Records

- We reviewed 20 sets of notes across surgical services. All medical records were stored in an office away from public access and were managed safely.
- The records were legible and signed appropriately. They contained documentation of the patient diagnosis and management plan.
- The records contained risk assessments for blood clots, nutritional status, pressure areas and falls assessments.
- Where appropriate medical records contained full pre-operative assessments'
- Eight of the medical records we reviewed were on the vascular ward. There was a very high standard of documentation on this ward. This demonstrated the effort that ward staff had made to improve performance in medical record keeping.

Safeguarding

- The trust had safeguarding policies and procedures in place to protect vulnerable adults and children and staff knew how to access these. There was a trust wide safeguarding adult's team, consisting of three specialist nurses.
- Data provided to us indicated that 90% of surgical services staff had received safeguarding levels one and two for adults and children. Staff did not receive safeguarding children level three training despite 16 and 17 year olds being routinely admitted to surgical wards.
- We found that staff knew how to report safeguarding concerns and access the trust safeguarding team.

Mandatory training

- The trust had a programme of mandatory training in place. This included corporate training for subjects such as information governance and clinical issues such as medicines management. The trust has its own target for mandatory training which is 85%. Data provided indicated that 88% of surgical services staff had received their mandatory training this year. A breakdown of different staff groups who had undertaken mandatory training was provided by the trust.
- The senior nursing staff in the division reported that provision was made for staff to attend mandatory training. Ward staff, particularly in theatres reported that mandatory training had to be completed in their own time.

Assessing and responding to patient risk

- The trust used an observation and modified early warning score (MEWS) to monitor and respond to the medically deteriorating patient. There was a trust wide policy to support the use of MEWS and its implementation was monitored by regular audits of when medical support was requested, for what reason and the patient's MEWS score.
- Training in the use of MEWs was provided to all new trust staff as part of the policy.
- Staff reported that the policy worked well and medical staff responded quickly when requested.
- We observed the use of the five steps to safer surgery in theatres. This was conducted in an organised and logical manner. All staff, regardless of grade, were involved in the process.
- We also observed a safety huddle in theatres aimed at reducing risk through identifying issues of safety. The issues raised at the huddle we observed were about equipment, staffing and list organisation.
- A number of handovers were observed between theatre and recovery staff, which were thorough and addressed all pertinent issues and risks.

- Assessment of risks were carried out during the pre-operative assessment processes and reviewed on admission to the admission lounge. Patients were assessed for the risk of venous thromboembolism (VTE), allergies and tissue viability. Assessment for these recognised risks were audited on a trust wide basis.
- When admitted to surgical wards a number of risk assessments were carried out including falls, tissue viability, and nutritional status.
- Regular World Health Organisation (WHO) safer surgery audits were carried out on a monthly basis. We reviewed the audits for April, May and June which had 99.7%, 100% and 99.7% compliance with requirements.

Nursing staffing

- Nursing leaders calculated the nurse staffing levels using an acuity and dependency tool developed by the trust. This assessment was carried out every six months. There was also a continuous review of nurse staffing levels which enabled nursing leaders to adapt levels as soon as they became aware that care was falling below the desired standard. This responsive approach to nurse staffing was demonstrated when nurse leaders addressed staffing issues on two wards with high number of incidents which related to the delivery of nursing care by closing a number of beds on each ward. Ward managers and matrons assessed staffing levels daily and used staff in a flexible manner to cover identified gaps. However, in some instances it was not possible to cover one ward to the level required.
- The number of qualified nurses and unqualified nursing staff were prominently displayed in public areas. The numbers of qualified staff displayed included the shift co-ordinator, who should be supernumerary to staff numbers. On some wards the shift co-ordinator was supernumerary to staff numbers and on other wards they were not supernumerary. On one ward in particular, where the shift co-ordinator was not supernumerary we observed a lack of coordination, bells not being answered in a timely manner, untidy ward areas and ward equipment blocking resuscitation equipment.
- All areas were well staffed apart from the vascular ward (A1) and acute theatres. The vascular ward, which had high levels of patient acuity and dependency, was operating below appropriate numbers of staff. Data provided indicated that the vacancy rate on this ward was 30% and a staff turnover rate of 39%. Nursing leadership had acted upon nurse staffing concerns on the ward and had closed eight beds in response to staffing issues. Two of these beds had recently re-opened with very low dependency day case patients. Recruitment to the vacant posts was an important divisional objective for safety reasons and to obtain increased bed capacity.
- We visited this ward on three occasions. On each occasion the ward had less staff than planned. On one occasion the ward was down one member of staff and efforts to obtain bank staff to fill the position were unsuccessful. The acuity and dependency of the patients on this ward meant that being down one staff member impacted on the care delivered to patients. An example of this is that we found one patient who was very dependent, slipping sideways out of bed, unable to reposition himself. We alerted staff to the difficulties this patient was experiencing and they responded immediately. All the patients in this bay were highly dependent, grouped together because their high levels of dependency required greater observation. One patient was on an end of life care plan. On this occasion we observed that no nursing staff entered this bay for over ten minutes and the patients in the bay were not kept under observation.
- On a separate visit to the ward, relatives approached us to complain about the poor care and poor standards of cleanliness that operated on the ward the previous week. In particular they expressed concern that their relative was left in pain, that they'd found his medication on the floor, they had found him soaked in urine and that drinks were out of his reach. They commented that care and cleanliness had improved the week of the CQC visit. They also expressed concern about the lack of communication between staff, which they believed negatively impacted on the patient's care.
- Acute theatres also had a high vacancy rate. We found that there were 11 whole time vacancies and that this had only recently reduced from 18. These posts were being back filled by over-time, bank and agency, but staff reported that it was difficult to fill all shifts. Staff reported that it was difficult to fill the empty posts because of poor morale and the effects of the recently undertaken theatre consultation document.
- Data provided to us indicated that there was little difference between planned nursing staff numbers and actual numbers. A trust wide formal acuity and dependency assessment was undertaken every six

months. An assessment of each ward's acuity and dependency was undertaken every day by ward managers and escalated to matrons if there was a staffing deficit. The ward managers we spoke to felt that the planned staffing reflected their actual staffing needs. Ward managers reported that the skill mix was appropriate to the numbers and acuity levels of their wards. They also reported that they felt supported by matrons and senior clinical nurse leaders. Staff commented that they felt confident to raise staffing issues with senior nurses and their concerns would be addressed.

Surgical staffing

- Medical staff skill mix for this trust was similar to the England average. There were slightly lower proportions of middle grade doctors, who are doctors with at least three years' experience. There is a higher percentage of registrar grade doctors and less junior doctors.
- There were sufficient numbers of medical staff within surgical services. We were told that there was consultant cover every day and at the weekends. Out of hours cover was provided on a shift system for junior doctors and by bleep for higher grade doctors.
- There were a wide number of surgical specialities within surgical services and junior doctors reported satisfaction with the training opportunities offered.
- Locum use for surgical specialties was low at between 5% and 8%.
- Staff from a number of different disciplines mentioned one surgical ward where consultant cover was poor, with one consultant not attending the ward to see patients. It was reported that this fostered poor interdisciplinary relationships between nursing and medical staff. It was also reported by members of different professional groups that junior medical staff on this ward received little support. This was raised with a clinical director who agreed that this was the case.

Major incident awareness and training

- The trust had a major incident plan in place, which was stored on the trust intranet site. Staff were able to tell us how they would access the policy.
- Staff demonstrated a good understanding their personal responsibility and the actions they would take in the event of a major incident. Senior staff understood the role their own clinical area had to play in a major incident.
- Major incident training was not part of the annual mandatory training programme.

Are surgery services effective?

Good

Surgical services at the trust provided patients with effective care and treatment, which followed national guidelines recommended by National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons. Local policies and procedures were developed in line with national guidelines and adherence to these policies was regularly monitored. Surgical services participated in national audits and performed better or the same as peers in these audits. There was also a well-developed programme of local audit activity which was regularly monitored.

Patient outcomes for the services provided are either better than the England average or the same as the England average. In most cases patient's pain was well managed. It was assessed pre-operatively for the elective patient and assessed again used a pain scoring tool when a patient arrived on a surgical ward. On most wards patients reported that they received their pain relief promptly. There was good input from the trust wide pain team, who attended wards on a daily basis to advice staff and patients on pain management issues.

There was good multidisciplinary working across surgical services, especially in the highly specialist areas of burns and plastics and the transplant unit. Nutritional and hydration needs were assessed on admission and reviewed regularly. Staff demonstrated a good understanding of consent and how to access support when patients were not able to give consent on their own behalf.

Evidence-based care and treatment

- Patients received care and treatment in line with recommended national guidelines from NICE and the Royal College of Surgeons, which was regularly audited by the trust's involvement in a wide range of national and local audits.
- An example of the trust's compliance with NICE guidelines is that all colorectal surgeons were able to

undertake laparoscopic colorectal surgery for suitable patients. Laparoscopic surgery is known have advantages for selected patients in terms of length of stay.

- There were a number of enhanced recovery programmes in place across surgical services. Enhanced Recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery. Evidence has shown that patients on an ER pathway are involved with the planning of their operation, receive smoother rehabilitation and return to normal activities more quickly.
- Local policies and procedures were developed in line with NICE guidelines. An example of this introduction of a clinical pathway for patients with an abdominal aortic aneurysm by the vascular service.
- Surgical services participated in national and local audits to benchmark trust performance against peers. Examples of participation in national audits are adult cardiac surgery, national falls audit, national burns assessment, national cancer audits, national limb injuries database, transplant services and multidisciplinary team working in lower gastro-intestinal surgery.
- Surgical services were involved in a range of local audit activity including audit of the quality of joint replacement coding, routine surgical interventions pathway, safe surgery and consent.

Pain relief

- Patients' pain requirements were assessed pre-operatively for elective patients. A pain management plan of care was discussed with the patient and shared with teams if needed for attention during and after surgery. Pain relief was administered in the recovery area during the immediate post-operative period.
- When patients arrived on the ward a scoring tool was used to assess their pain. On our review of patient notes, we found that pain score documentation was completed and patients' pain scores were reviewed at regular intervals.
- Surgical wards had good links with the trust pain team. The pain team contacted the ward every morning to identify if any patients require their support. If there is a patient identified, they will come to the ward and assess the patient. They were also able to be contacted at any point in the day visited immediately if required. The pain team also provided training to new starters and experienced staff on the ward.
- On most wards patients commented to us that staff managed their pain very well and responded to complaints of pain immediately. On one ward three patients/relatives raised the issue of pain relief not being provided in a timely manner. One of these patients commented that she was often left in pain, waiting for her pain relief, when the member of staff dispensing medications was called away to other tasks. Another patient commented that staff were slow with his pain tablets. The issue of pain relief was raised with the matron for the ward during the inspection.
- We looked at the pain assessments on this ward and they were completed in full for all patients. The prescription charts were also completed.

Nutrition and hydration

- The nutrition and hydration needs of patients who were on a ward for more than six hours were assessed using the malnutrition universal screening tool (MUST). Where patients were identified as at risk, they were referred to a dietician, who undertook a detailed assessment. If a patient was identified as requiring support with nutrition or hydration needs a red tray system was used. This acted as an alert for staff responsible for giving out meals and drinks.
- In all of the 20 sets of notes that we reviewed, documentation relating to hydration and nutrition was completed, this included MUST screening documentation and fluid balance documentation.

Patient outcomes

- The trust had about the same relative readmission rates as the England average for all non-elective and elective surgery, with some variation between surgical specialities. Relative readmission rates for urology and general surgery were better than the England average.
- Thoracic surgery and trauma and orthopaedic surgery were slightly worse than the England average. This picture was repeated for the relative risk of readmission at Wythenshawe hospital.
- Surgical services participated in a number of national clinical audits, including the national bowel, lung, hip fracture audits. In 2015 the service also participated in the national emergency laparotomy audit.

- The national bowel cancer audit measures a number of outcomes which indicate the standard of care offered to bowel cancer patients. The trust results indicate that bowel cancer patients receive treatment that was in line with national guidelines. For most indicators the trust performed around the same as the England average and for some indicators, such as the involvement of a clinical nurse specialist and CT scans undertaken, the trust performed better than the England average.
- The national lung audit measures a set of indicators related to the care and treatment of people with lung cancer. The trust performed the same as England average which indicates that patients received care and treatment that was in line with national guidelines.
- The national hip fracture audit measures indicators related to the care and treatment of patients admitted to hospital with a fracture of their hip. The trust's performance in relation to the indicators was mixed. The trust performed better than the England average for pre-operative assessment by a geriatrician, surgery on or after the day of admission, bone health medication assessment and falls assessment. The trust performed worse than the England average for being admitted to orthopaedic care within four hours and the average length of stay.
- The trust participated in the national emergency laparotomy audit (NELA) in 2015, which uses 11 indicators to assess the care and treatment of patients requiring emergency laparotomy. The trust's performance against these indicators was variable. A consultant surgeon was reported as present in theatre in over 80% of cases. However, less than half of patients over 70 were seen by a specialist in medicine for care of older people (MCOP).
- Performance reported outcome measures (PROMS) assess the quality of care a patient received, from the patient's perspective. PROMS ask patients how treatment has improved the quality of their lives. The PROMS data for April 2104- April 2015 for groin hernia, hip and knee replacement and varicose veins was the same as the England average.

Competent staff

- Most surgical staff had received an appraisal in the past year.
- There was a well-developed preceptorship programme in place to support newly qualified nursing staff nurses.
- All staff reported that they felt there were good development opportunities and they were supported to develop in their career.
- Surgical services identified a gap in support for nursing staff and created an informal role of senior staff nurse, which was displayed on a name badge.
- The trust offered the LEAD programme to all members of staff, which surgical staff accessed. This programme included the development of management skills and offered tools such as 360 degree feedback.
- We observed that surgical services took staff development very seriously and were prepared to develop tailored programmes to ensure that staff were competent.

Multidisciplinary working

- There were systems for effective daily communications between multidisciplinary teams across surgical services. Staff handovers took place twice daily on all wards, at shift changeover times. In addition to staff handovers, each ward had a multidisciplinary safety huddle each morning.
- A multidisciplinary safety huddle was also observed taking place in acute theatres and the WHO checklist was carried out by a multidisciplinary team.
- We observed a wide range of professionals working on surgical wards, including physiotherapists, occupational therapists and pharmacists. Access to members of the multidisciplinary team was by referral and ward staff understood the processes for requesting referrals.
- Data supplied to us indicated that allied health professions staffing levels were as planned across surgical services, apart from burns and plastics and orthopaedics. Orthopaedics received less occupational therapy than was planned in July, August and September, but this situation had resolved in October 2015. Plastics received less occupational therapy support than was planned in July, September and October 2015.
- We observed excellent multidisciplinary team working across surgical services. We observed an example of this strong multidisciplinary team working during the inspection process when a diverse multidisciplinary team was convened to address the needs of one patient with complex medical, social and psychological needs.

This included therapists, nurses, medical staff and legal representation was convened by the ward manager. The manager reported that this team worked well together with the aim of supporting the patient's best interests.

- Therapy staff on one ward, where there were a number of patients with complex medical and rehabilitation needs, reported repeatedly requesting a multidisciplinary team meeting, but this had never been established.

Seven-day services

- Elective surgery was carried out Monday to Friday. However, some elective surgeries were carried out on Saturdays as part of a waiting list initiative.
- Staff reported that most consultants were available at weekends to attend the ward to carry out ward rounds
- Emergency theatres were available 24 hours a day seven days a week. These theatres were fully staffed with nursing, operating department practitioners, consultant surgeons and consultant anaesthetists.
- Pharmacists covered the wards between Monday and Friday. The pharmacy was open over seven days and there was an on call pharmacist if required.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner, including test results, risk assessments and medical and nursing records**.**
- All the wards we visited used a smart board, which was an electronic screen that was updated by staff with regards to patient name, location on the ward, and any risks identified.
- The trust used a paper based system for medical and nursing records. These records were stored securely away from the ward area in lockable offices.
- There were computers available on the wards we visited that staff were able to access for patient results and trust information.
- Policies, protocols and procedures were kept on the trust intranet, and wards had copies in the office.
- We observed that there were files containing minutes of meetings and protocols that were available to staff.
- We observed that patient records were complete and up to date. They were easy to follow and contained all the relevant information. Patient records contained detailed admission information and discharge summaries.
- We saw examples of where letters had been sent to GPs on patient discharge, which were comprehensive.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the trust and allowed local staff to view images on the ward, promptly.
- The theatre department used an electronic system to capture information about patient scheduling and theatre utilisation. This was supported by a paper based system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to surgical procedures was obtained during the pre-admission and admission procedures. The consent form was a standard form outlining the risks and benefits of the procedure. The consent form was appropriately signed in all records that we reviewed.
- We found that staff understood how to seek consent from patients, both formal written consent, verbal consent and implied consent. One patient commented that a nurse had asked permission to site a catheter and the patient was pleased to be asked.
- Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DOLS).
- Staff understood how to access support from the trust wide safeguarding team if there were any issues with mental capacity assessments. One member of staff related her experience of doing so and she found the team helpful and supportive.

Are surgery services caring?

Good

Staff were observed providing compassionate and caring treatment to patients across all specialities. We observed patients waiting for their procedures in theatre and in recovery following their procedures. Staff were comforting and reassuring and listened to how patients were feeling. We observed staff delivering care on wards and noted that they listened to patients and treated them with kindness

and consideration. Patients and relatives told us that staff were very caring and treated them with respect. We were also told that patients and relatives felt involved in their care and that staff would discuss treatment options with them.

Compassionate care

- We observed staff delivering compassionate and caring treatment to patients across all specialties. Theatres and recovery staff were kind and reassuring to patients while they were waiting to go into theatre and when they were in the recovery area. Ward staff interacted with patients in a respectful and caring manner.
- There were numerous examples of kindness and compassion that we observed and heard about from patients/relatives and other staff.
- One example was reported to us of staff buying a Christmas present for a patient who was going home at Christmas alone. Relatives told us about the junior doctor who intervened when he saw that they were very distressed about their relative and worked very hard to ensure that the correct referrals were in place for end of life care.
- The Friends and Family Test (FFT) is an NHS tool that enables patients to give feedback on their experience of NHS care. The trust response rate to the questionnaire was 38.9%, which is above the England average of 35.5%. For surgical services response rates varied for wards from 31% to 67%. This means that a lot more patients responded to the questionnaire than at trust level. Of those patients who responded to the questionnaire, almost 100% answered that they would recommend the service to friends and family.
- We spoke with 24 patients/relatives and received one wholly negative account of patient and family experience. Patients and relatives were very pleased with the care they received as shown by comments such "They've been brilliant." "If you need anything, they are straight there." "I got pain relief straight away, they didn't leave you hanging about.", "They've been belting!"
- The only expressed area of dissatisfaction was with the cost of parking and the cost of the TV. A number of patients and relatives commented that parking costs and TV costs were too high.

Understanding and involvement of patients and those close to them

- We spoke with a number of patients and relatives who commented that staff kept them informed about their care at all times.
- Patients who had come in for elective procedures felt well prepared for their procedures through the pre-admission processes.
- Patients reported having discussions with medical staff who set out the different treatment options open to them

Emotional support

- We observed staff providing reassurance and comfort to patients from the pre-operative and post-operative phase of treatment.
- There was psychological support for patients undergoing transplant procedures. A drop-in facility called the Transplant Café was available to patients and relatives who were having or who had received transplants.

Are surgery services responsive?

Requires improvement

Surgical services experienced difficulties with bed capacity, which prevented patients accessing planned surgery in a timely manner. These difficulties included the increased use of surgical beds for medical patients, delayed transfer of medically fit patients who require additional care and the closure of 12 surgical beds because of staffing issues. There was also a higher than anticipated demand for vascular beds. The lack of surgical bed capacity resulted in higher than average cancelled operations, failure to rearrange cancelled operations in a timely manner and an overall failure to meet referral to treatment times for planned surgical procedures.

The divisional management and the division's clinical leaders were fully aware of the poor performance and had thoroughly investigated the reasons for difficulties with bed capacity. The recovery plan to improve performance in cancelled operations and referral to treatment times for planned surgery relied upon the opening of a new hybrid theatre in April 2016. In turn, the opening of the new theatre relied upon the re-opening of closed beds on the vascular and trauma and orthopaedic wards, which would provide 12 more beds. These beds were closed because of difficult staffing issues, which had not been resolved at the time of

our inspection. Nursing leadership was clear that these beds could not open in the near future. The lack of clarity regarding future bed capacity made it unclear if the recovery plan would deliver the planned improvements in performance against set timescales. In addition to the closed beds, the wider trust issues of ongoing emergency department pressures and delayed transfers of care, continued to put pressure on surgical bed capacity.

Surgical services had undertaken reviews of service planning and had adapted to the new demands facing it. A short stay ward had been transformed into a day-case facility, which increased trust capacity to meet the increased demand for day case procedures. Work had been undertaken in each speciality to ensure that admission procedures were smooth and efficient, resulting in fewer cancelled operations for clinical reasons.

Surgical services were responsive to the needs of patients with complex needs.

Service planning and delivery to meet the needs of local people

- The trust provided a wide range of general and specialised surgical services to both the local and regional population. This included specialist orthopaedic services, breast and colorectal surgery, kidney transplant services and a regional burns and plastics unit.
- Surgical services were organised to provide efficient access to surgery and had adapted to meet new demands on the service. An example of this is the change of a ward from a short stay facility to a day case facility, which increased trust capacity for day case surgery. There are facilities within surgical services to perform minor procedures outside of main acute theatres.
- There was access to emergency theatres 24 hours a day, seven days a week for general surgical emergencies and trauma cases.
- Surgical services recognised that there was an increase in the numbers of people with dementia that were being admitted for orthopaedic surgery. It had recently recruited an orthogeriatrician in order to meet this changing demand.
- Following the decision by local commissioners regarding Healthier Together, it is anticipated that the Trust will lose some of its emergency surgery services. The impact on UHSM is unclear at present as pathways are still being developed.

Meeting people's individual needs

- Most surgical services provided a high standard of care for patients with complex needs.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed that they knew how to access the online service. If a patient was unable to speak English, the trust had a policy of not using family members. Although the only English versions of leaflets were available in ward areas, staff knew how to access copies in accessible formats if required.
- Staff were observed adapting how they delivered care to patients, depending upon their needs. One example of this is that during mealtimes we observed staff assisting a patient who was unable to feed herself. In another example a member of staff was signing to patient, who was deaf, to communicate about pain relief.
- Medical staff also adapted their approach according to the needs of patients. One lady, who was admitted as an emergency, required surgery but was afraid of a general anaesthetic. She discussed her fears with medical staff who talked through different options available to her.
- The quality of information on wards was variable. Some wards had a lot of leaflets prominently displayed and others had very few. The leaflets that were available were only available in English.
- A considerable amount of information was available on the trust website and procedure specific information was sent to elective patients prior to admission.
- On the transplant unit a multidisciplinary patient booklet had been developed, which gave information about what happens in the transplant service.
- Surgical services considered the needs of people with dementia. One ward had trained dementia specialists as they had a lot of patients with dementia on the ward.
- There was accommodation available for relatives of transplant patients who lived outside of Manchester. This was run by a local charity. This facility could also be used by transplant patients who required a bridge from hospital to home.

Surgery

Access and flow

- The trust experienced difficulties with access and flow across surgical services. These difficulties were evident by the high number of medical outliers occupying surgical beds, the high number of cancelled operations, the trust's failure to meet 18 week referral to treatment targets (RTTs).
- There were good pre-admission and admission procedures for elective surgical patients. All elective admissions were admitted to an admissions lounge, on the morning of surgery. Senior clinicians informed us that a substantial amount of activity had been undertaken, by each surgical speciality, to improve the pre-operative assessment of patients. We were told that the introduction of a surgical admissions lounge and better pre-operative assessment had made the admission processes more efficient.
- There was a surgical assessment unit (SAU) for emergency admissions. The SAU was an eight-bedded unit, divided into two four-bedded bays. The pathway into SAU was through a surgical decision made in the emergency department or by a general practitioner. Patients could remain on SAU between two hours and two days, with the majority staying on the unit for 24 hours. Nursing Staff reported that access to junior and senior medical staff was good, which helped with the smooth movement of patients through the unit. The unit had its own patient flow co-ordinator who facilitated efficient throughput of patients.
- Staff identified that a number of surgical beds were occupied by patients who did not require an acute surgical bed, but could not be discharged home. On one ward, out of 20 beds, there were four delayed discharges. Three of these patients were waiting for social care input and one patient was waiting for reasons not connected to social care. On another ward, out of 24 beds, six patients' discharges were delayed waiting for either an intermediate care bed or for social reasons. Staff were able to identify the CCG which was experiencing the most difficulties with discharges and trust management were aware of the matter.
- The average bed occupancy was over 95% for all surgical beds in the trust. NHS England assessed that average bed occupancy of above 85% reduces the effectiveness of care.
- Twelve beds were closed across two surgical wards, due to staffing issues, which impacted on bed availability and occupancy across surgical services. Two of these beds had recently been opened for a low risk day case procedures.
- The average length of stay in a hospital bed for both elective and non-elective surgical patients was about the same as the England average for all surgery, apart from orthopaedics. In orthopaedics, the trust average length of stay for non-elective procedures was 10.5 days compared to the England average of 8.7.
- We were informed by senior divisional managers that there were a high number of surgical beds that were occupied by patients that should have been on a medical ward. Divisional managers told us that when surgical beds were filled with medical patients, surgical bed capacity reduced, which impacted on cancelled operations. In particular, it was reported that high numbers of urology beds were occupied by medical patients, which impacted on the trust's ability to meet its RTTs for urology. A number of staff from each ward raised the matter of surgical beds being occupied by medical patients with us. On one specialist surgical ward, 15 out of 21 beds were filled with patients not from the specialty.
- Data provided to us by the trust indicated that there were high numbers of late cancelled operations. This trend began in the last quarter (Q4) of the year of 2013/14 and the number of cancelled operations has continued to increase since that time. From July 2015 to January 2016 there were 529 cancelled operations. The majority of these cancellations occurred in plastic surgery (121) and cardiac surgery (119). The most common reasons for the cancellation of an operation, for all surgical procedures, were related to patient flow; in particular, no ICU/ward bed being available and emergency/trauma cases taking a priority.
- The trust had a target of 0.8% of late cancelled operations for non-clinical reasons, but has been missing this target for some months. The worst performance was in October 2015 with 2.37% of operations being cancelled at the last minute. Performance for November and December did improve slightly and was 1.64% and 1.67%, respectively.
- The percentage of overall cancelled operations, compared with the number of elective admissions, was

slightly worse than the England average. The percentage of patients whose operations were cancelled and not treated within 28 days was also worse than the England average.

- Discussions with clinicians revealed that it was not uncommon for operations to be cancelled on the day of surgery, after the patient has been admitted to the admission lounge, and in some cases kept "nil by mouth" for some time. Whilst observing in theatre and on the admission lounge, inspectors saw that there were a number of patients who were waiting for beds to be identified before their procedure could begin.
- The scheduled care divisional performance reports for October 2015 identified that theatre productivity was down to 66.7% against a trust target of 90%. The same document comments that theatre productivity has been steadily deteriorating over the past six months.
- The division's senior clinicians and divisional management were fully aware of the trust's rising number of cancelled operations. The number of cancelled operations was monitored on a weekly basis and reported monthly at directorate, divisional and trust board level. Clinicians had taken action to ensure that operations were not cancelled for clinical reasons such as unidentified medical conditions or inappropriate procedures. Monitoring data provided by the trust supported the success of the clinical work undertaken in this area, in that no operations were listed as cancelled for clinical reasons that could have been foreseen. Scheduled care divisional management identified that the reason for the high number of cancelled operations was rooted in the lack of capacity of the trust to make appropriate beds available.
- A cancelled operations recovery plan provided indicated the trust was taking a number of actions to improve the number of cancelled operations including a cancelled operations escalation plan and a bed reconfiguration.
- The trust did not meet the national waiting time target of 18 weeks from referral to treatment for the period from September 2014 to August 2015. However, trust performance against the 90% target was variable across surgical specialities. In particular, general surgery (80%), trauma & orthopaedics (80%), ear, nose and throat (ENT) 87% were all below target. Urology, oral surgery, plastic surgery and cardiothoracic surgery all performed above target. Overall, trust performance against this target deteriorated over the past year.

Divisional management were aware of the failure to meet RTT targets and had undertaken investigation into why this was happening. We were informed that although decreasing capacity within the trust explained the overall performance, other issues were pertinent to particular specialities. For example, ENT lost a productive surgeon and failed to recruit a replacement. The designated trauma and orthopaedic ward had closed four beds due to staffing difficulties. This impacted on capacity of planned orthopaedic surgery as trauma patients were being cared for on the elective orthopaedic ward.

Learning from complaints and concerns

- The trust undertook a monthly patient survey and results were provided at ward level. It also monitored complaints by ward. The vascular ward (A1) had a high number of complaints compared to most other ward over the past 12 months. This was one of the indicators which alerted clinical leaders to difficulties on the ward. In response to these difficulties, clinical leadership had put in place ward based training led by the new clinical director for vascular surgery and reviewed the competencies. This ward has also recruited a new band six nurse specifically to address the issue of pressure ulcers on the ward.
- Some wards did not display information that explained how patients or relatives could complain about the care they were receiving.

Are surgery services well-led?

Good

Surgical services were well led, from the senior divisional structures to ward level, in most instances. Divisions were structured around a unified triumvirate model. This was a model that aimed to join business, medical and nursing leadership in order that patient safety and care had the same priority as performance targets. The trust's vision was embedded across surgical services and staff spoke passionately about their commitment to deliver safe patient centred services. There were robust clinical and corporate governance frameworks in place, which provided effective feedback mechanisms about the performance of services. Divisional leadership monitored performance against key quality indicators including quality, safety and activity. The robust governance structures enabled this

information to be fed up to the trust board and down to ward and theatre staff. All staff demonstrated appropriate awareness of the governance structures and of the performance of services against performance indicators. Risks were appropriately identified, investigated and addressed.

High staff morale was evident throughout the service, apart from very small pockets of low morale, related to specific reasons. The majority of staff felt valued and respected, with the exception of those staff mentioned.

The leadership across surgical services demonstrated that it was aware of the areas of the service that was experiencing difficulties providing safe and care and treatment to patients. However, through interview and observation, we found that the divisional leadership was not fully aware of the challenges one ward was facing in terms of clinical leadership. Both the nursing and medical leadership of one particular ward were not addressing fundamental issues of care and treatment, which needed to be addressed before safety issues could be resolved.

Vision and strategy for this service

- The trust had a vision for its services and clearly stated its aspiration to be a top ten NHS provider in the country. This vision was supported by a pledge to deliver safe, first class patient care in line with our vision, mission and values. The trust stated core people based values which guided the way it worked. This included putting patients first, excellence, one team, being open, which meant learning from mistakes and demonstrating courageous leadership.
- There was no one document which articulated a clear vision for surgical services. However, throughout surgical services staff demonstrated that they had a clear understanding of the trust's mission and championed the values which the trust expressed.

Governance, risk management and quality measurement

- In surgical services there were robust clinical and corporate governance structures in place, which provided a clear reporting mechanism to the trust board.
- Managers produced monthly divisional reports for the trust board, which communicated divisional performance across a wide variety of areas. This report also clearly identified any risks which arose from difficulties meeting performance targets.
- We saw minutes of clinical governance meetings and a monthly divisional report and discussed the performance reporting mechanism with senior staff.
- Managers monitored performance against key quality, safety and performance targets, through information processes. This enabled managers to maintain a thorough understanding of performance.
- The performance of surgical services was cascaded downwards to ward and theatre staff through meetings and the use of performance dashboard.
- The quality of surgical services was regularly monitored by the use of audit and included in the reporting structures.

Leadership of service

- Clinical and managerial leadership of surgical services was unified. This was facilitated by a triumvirate divisional management team. The triumvirate included a divisional senior manager, divisional medical director and divisional nursing lead. We found the leadership to be open and honest in all our discussions about the different aspects of the service.
- We were unable to speak with the divisional medical director but interviews with the divisional manager and nurse indicated a shared vision of the service. The divisional manager articulated a strong focus on clinical quality and the provision of surgical services which were safe.
- The divisional management team were aware of the difficulties with staffing on particular wards and its impact on the quality of care delivered. The divisional nurse was proactively dealt with the situation and had attempted to put in place measures to reduce the impact that low staffing had on the patient experience.
- We found that, although the divisional leadership was aware of the difficulties that existed on one ward, in terms of staffing and its impact on the quality of care delivered, they did not fully understand why the changes implemented had not produced tangible improvements in care on a particular ward.
- Significant attention and resource had been targeted at this ward, including organisational development programmes to develop junior staff. Band six

appointments had very recently been made from the existing band five staff nurses. These staff were inexperienced and could not act as clinical leaders. A nursing leader agreed that they were acting at a band five level and could not provide clinical leadership to junior staff. The recently appointed ward manager was supported in terms of developing management skills, but we saw no evidence of clinical mentorship by the next level of clinical leadership. The new ward manager only received two supernumerary sessions per week in which to deal with her management responsibilities.

- In addition to nursing leadership, there was a long standing issue with medical leadership on the same ward. This had not been addressed at divisional level and continued to impact on the care delivered on the ward.
- Divisional leadership did not appear to understand how the difficulties that were present on this ward, in terms of clinical leadership, were making a significant contribution to the difficulties experienced with bed capacity and flow across surgical services.

Culture within the service

- Most staff we spoke with reported a high level of morale. Even staff on wards that were experiencing difficulties were positive and felt supported by senior management and clinical leaders.
- Staff repeatedly commented that they felt respected and listened to by nursing leaders. They reported that they felt confident raising a matter of concern with senior management and that their concerns would be responded to appropriately.
- It was also evident that staff instigated and led service developments and that they contributed views about service developments.
- Some key staff reported that they were not supported in their role and that their seniors were rude and abrupt to them. This view was corroborated by a number of staff from a variety of professional backgrounds.
- Staff reported good access to professional training. The trust developed creative training packages which enabled staff to access individualised training programmes, relating to particular skills they wished to acquire. An example of this is the organisational development programme which had been put in place on a ward with new and inexperienced staff.

Public engagement

- Patients' views about the service were routinely sought out for every admission and procedure.
- There were high levels of positive feedback from the Friends and Family Test. The Friends and Family Test is an NHS wide initiative providing people with the opportunity to feedback to a trust about the care and treatment they received.

Staff engagement

- A monthly communication provided for scheduled care from divisional management.
- Communication was disseminated from their line managers, from team meetings and during huddles.
- The trust also engaged with staff via emails, newsletters and through information displayed on notice boards in staff areas.
- The trust celebrated the achievements of staff in a number of ways including an annual event where staff had their accomplishments and achievements recognised. An example of this is the award given to the trauma and orthopaedics ward, for being an outstanding clinical placement for nursing students from a local university.
- The trust had reviewed the findings from the 2014 survey of NHS staff, the majority of which were positive. The survey found that staff felt positive about working for the trust and that there were sufficient opportunities for them to develop their career in the organisation.

Innovation, improvement and sustainability

- Clinical staff and managers were continually striving to improve the care and treatment delivered to patients and we were given a number of examples of innovation. These innovations were communicated to staff via the monthly newsletter produced by the scheduled care division.
- The introduction of a post which combined the roles of pelvic floor specialist and surgical care practitioner to the faecal incontinence service brought benefits to patients increased the effective use of financial resources.
- The plastic surgery trauma team altered the way the service is delivered whichresulted in a reduction in the length of time trauma patients waited for their surgery and reduced the number of admissions to the plastics ward.
- Orthopaedics and trauma nurses had implemented a virtual fracture clinical for patients.

Surgery

- An elective orthopaedics joint school, which used a multidisciplinary approach, was implemented which prepared patients elective hip and new replacements.
- Colorectal surgery had implemented a multidisciplinary bowel school to prepare patients for elective surgery.
- The urology service implemented a one stop haematuria clinics and a nurse consultant led urology assessment unit.
- Enhanced recovery pathways had been implemented in all specialities.

Critical care

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

Information about the service

The critical care services are based at Wythenshawe hospital. The adult intensive care unit provides care for up to 17 patients, including nine level three (intensive care) patients and eight level two (high dependency) patients. The burns unit has a separate intensive care unit for up to five patients with two intensive care beds and up to three high dependency beds.

The North West Heart Centre is located at the hospital and includes a 26-bedded cardiothoracic critical care unit that could be increased to 31 beds when required. This includes two beds funded for extracorporeal membrane oxygenation (ECMO) patients. ECMO is used when a patient has a serious condition which prevents the lungs or heart from working normally.

The critical care services are consultant-led and provide specialist and secondary care and treatment to adult patients with a range of serious life-threatening illnesses in Wythenshawe, Trafford and the wider Greater Manchester area. Patients could be admitted to the critical care services via the emergency department or from the wards and operating theatres across the trust. Patients transferred from other hospitals are accepted onto the intensive care unit as part of the critical care network. The cardiothoracic unit also accepts patients requiring ECMO treatment from other hospitals across the country.

We visited Wythenshawe hospital as part of our announced inspection during 26 to 29 January 2016. We also carried out an out-of-hours unannounced visit on 11 February 2016. As part of the visit, we inspected the acute intensive care unit (AICU), the burns intensive care unit and the cardiothoracic critical care unit (CTCCU).

We spoke with four patients and the relatives of four patients. We observed care and treatment and looked at 10 care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, pharmacists, practice educators, physiotherapists, a critical care outreach practitioner, the critical care matrons and the lead consultants for the AICU and CTCCU. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Critical care

Summary of findings

We gave the critical care services at Wythenshawe hospital an overall rating of good. However, we found further improvements were needed in relation to how the service responded to patient needs.

This was because there was insufficient capacity within the critical care services which meant patients were not always admitted promptly to receive the right level of care. NHS England data showed bed occupancy levels between May 2013 and March 2015 were consistently higher than the England average. The high bed occupancy levels in the critical care services meant operations were cancelled due to the lack of available critical care beds.

As part of the trust's escalation policy, patients were transferred to the main theatres recovery area when there were no critical care beds available. There had been 59 occurrences of patients being nursed overnight in theatre recovery from April 2015 to October 2015. Patients kept overnight in recovery were assessed by critical care consultants. However, they were cared for by recovery nurses that had not completed all the relevant competencies to treat critically ill patients. There were plans in place to provide training for recovery staff by the end of March 2016.

Patients were not always discharged from critical care in a timely manner due a lack of available ward beds and capacity constraints across the trust. ICNARC data up to September 2015 showed the number of reported delayed discharges (within and greater than four hours) was worse than other comparable units nationally. The data showed the delayed discharges were consistently 10% to 20% above the average since January 2013.

The critical care services had implemented a new patient flow policy in December 2015 to improve access to critical care and reduce delayed discharges. There was also a plan to open a ten-bedded long term ventilation unit with two beds for weaning by July 2016 that was expected to free up capacity and improve patient access to the acute intensive care unit (AICU).

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises and were supported with the right equipment. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating.

Patients were supported by trained, competent staff. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. Patients and their relatives spoke positively about the care and treatment provided. They were treated with dignity, empathy and compassion and supported with their emotional and spiritual needs.

The services provided care and treatment that followed national clinical guidelines and performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit. There was effective teamwork and clearly visible leadership within the critical care services and staff were positive about the culture and level of support they received. Key risks to the services, audit findings and quality and performance was monitored though routine departmental and clinical governance meetings.

Critical care

Are critical care services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

The majority of staff had completed their mandatory training and the hospital's internal target of 85% compliance in mandatory training was achieved. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks.

Incidents

- The strategic executive information system data showed there were no serious patient safety incidents reported by the critical care services between August 2014 and July 2015.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Staff told us they were encouraged to report incidents and received direct feedback from the matrons. Incidents logged on the system were reviewed and investigated by the matrons to identify learning and prevent reoccurrence.
- Staff told us incidents and complaints were discussed during weekly and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through monthly newsletters.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The incident reporting system provided prompts for staff to apply duty of candour (being open and honest with patients when things go wrong) for incidents that had led to serious or moderate harm.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed at audit meetings every three months.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- The critical care services had low levels of falls with harm, infections and pressure ulcers. Safety Thermometer information showed there were no falls with harm, two catheter urinary tract infections and 14 pressure ulcers reported by the hospital relating to critical care services between September 2014 and September 2015.
- Information relating to the safety thermometer outcomes was clearly displayed on notice boards within the acute critical care unit (AICU) and the cardiothoracic critical care unit (CTCCU).

Cleanliness, infection control and hygiene

- There was one case of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection and one case of Clostridium Difficile (C.diff) infection reported over the last 12 months related to the AICU.
- We looked at the investigation report and action plan for the MRSA incident that occurred in September 2015. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- There was one case of MRSA bacteraemia infection and one case of C.diff infection reported over the last 12 months across the CTCCU. The MRSA infection occurred during December 2015 and a root cause analysis investigation was underway to determine the cause and identify any improvement that could be made.
- Intensive Care National Audit and Research Centre (ICNARC) data up to September 2015 showed that unit acquired MRSA, C. diff and blood infection rates were within expected levels compared to the England average.
- All patients admitted to the critical care services underwent MRSA screening procedures. Patients identified as at risk were also screened for Carbapenemase-producing Enterobacteriaceae (CPE) infections.
- There had been 24 incidents of ventilator-associated pneumonia (VAP) identified in the AICU between February 2015 and November 2015. Patients identified with VAP received safe and appropriate treatment

through the use of a recognised ventilator care pathway, which included placing the head of the bed at 30-45 degrees angle, daily oral care with Chlorhexidine and the daily sedative interruption and daily assessment of readiness to extubate (removal of tubing from a patient's airways).

- The AICU and CTCCU critical care units were clean, tidy and maintained to a good standard. Staff carried out a monthly audit to monitor cleanliness standards of the equipment and general ward environment. Audit results between August 2015 and October 2015 showed the AICU achieved 97% compliance and CTCCU achieved 95% compliance during this period. There were action plans in place where issues were identified and these were followed up during the next monthly audit.
- Staff demonstrated adherence and good awareness of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a sufficient number of hand wash sinks and hand gels available throughout the critical care units. Staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- We observed staff following hand hygiene and ' bare below the elbow' guidance. Hand hygiene audits were carried out on a monthly basis to monitor staff adherence to trust policies.
- Hand hygiene audit results between August 2015 and October 2015 showed both the AICU and CTCCU achieved 100% compliance during this period.
- The AICU had three single rooms and the CTCCU had six ensuite cubicles that could be used to isolate patients identified with an infection. We saw that appropriate signage was used to protect staff and visitors.

Environment and equipment

- The environment and equipment in the critical care units was visibly clean and well maintained. The clinical areas were tidy and free from clutter. Each patient bed area had an equipment trolley containing all the equipment required to treat the patient.
- The equipment we saw included labels showing they had been serviced and when they were next due for servicing. There was a sufficient quantity of specialist equipment available to treat patients. Equipment was serviced by the hospital's maintenance team under a planned preventive maintenance schedule.
- Staff told us that all items of equipment were readily available and bed spaces were equipped with the right equipment needed to treat patients, such as ventilators and intubation equipment (for placement of tube in patient's airways).
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled medicines, were securely stored. Staff carried out daily checks on controlled medicines and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. The ward staff were responsible for maintaining minimum stock levels and checking medication expiry dates.
- We saw that medicines that required storage at temperatures below 8ºC were stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- The AICU and CTCCU had dedicated pharmacists based on the units during weekdays. The pharmacists reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication charts for nine patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Staff used paper based patient records. We looked at the records for 10 patients. These were complete and up to date.
- The patient records included risk assessments, such as for venous thromboembolism (VTE), pressure care or nutrition and these were completed correctly.
- The patient records showed that nursing and medical assessments were carried out in a timely manner and documented correctly.
- Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Critical care

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 91% of AICU staff and 89% of CTCCU staff had completed training in adults and children safeguarding training. This was better than the trust target of 85%.
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was clearly displayed in the critical care units. Each unit also had a safeguarding link nurse in place. Staff could also obtain support and guidance from the trust-wide safeguarding team.
- Safeguarding incidents were reviewed by the matrons and also by the hospital's adult safeguarding committee, which held meetings every two months to review safeguarding incidents and look for trends and improvements.

Mandatory training

- Staff received mandatory training that included key topics such as infection control, information governance, equality and diversity, fire safety, health and safety, medicines management, safeguarding children and vulnerable adults, moving and handling and conflict awareness.
- Mandatory training was delivered on a rolling annual programme and monitored on a monthly basis.
- The overall mandatory training completion rate for all staff groups was 87% in the AICU and 85% in the CTCCU. This showed the majority of staff had completed their mandatory training and the trust's internal target of 85% compliance had been achieved.

Assessing and responding to patient risk

- Critical care staff carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.
- Staff carried out 'safety huddle' meetings twice a day where specific patient needs were discussed.
- Patient records showed that staff escalated concerns correctly, and repeat observations were taken within necessary time frames to support patient safety.
- Ward staff across the hospital used early warning scores. If a patient's health deteriorated, staff were supported with medical input and could access the critical care outreach team.
- The critical care outreach team provided cover for the wards and theatre recovery areas across the hospital over seven days between 8am and 8.30pm. Outside of these hours the 'hospital at night team' nurse practitioners received handover from the outreach team. Staff spoke positively about the support they received from the outreach team.
- Records showed the critical care outreach team had carried out a total of 3601 patient assessments between January 2015 and January 2016 across the hospital. The majority of assessments (70.5%) were for advice on patient management with a further follow up required.
- The outreach team also followed up all patients that had been discharged from the critical care services within 24 hours of discharge from the unit.

Nursing staffing

- Nurse staffing levels were reviewed every six months against minimum compliance standards, based on national guidelines for the provision on intensive care services (GPICS). The expected and actual staffing levels were displayed on notice board in each unit and these were updated on a daily basis.
- Nursing staff handovers occurred twice a day and included discussions around patient needs and any staffing or capacity issues.
- During our inspection the critical care services had a sufficient number of qualified nursing and support staff with an appropriate skill mix on each shift to ensure that patients received the right level of care.
- All intensive care (level three) patients were nursed on a one to one basis and all high dependency (level two) patients were nursed on a one to two basis in accordance with Intensive Care Society (ICS) guidelines.
- There was a separate matron for the AICU and the CTCCU and the matrons had overall responsibility for ward staff within the units. There was also a lead nurse (band seven) on each shift across both units that was supernumerary (i.e. additional to the staffing establishment) as recommended by ICS guidelines.
- The staffing establishment in the AICU was for at least 13 trained nurses during the morning, evening and night shifts. There were vacancies for four whole time equivalent band five nurses and three band six nurse in the AICU. Recruitment to fill these posts was ongoing with three nurses awaiting start dates and an additional candidate at interview stage.

Critical care

- The burns unit included a critical care area that could accommodate up to two intensive care (level three) patients and up to three high dependency (level two) patients. This area was appropriately staffed by critical care trained nurses with a supernumerary lead nurse on each shift.
- The staffing establishment in the CTCCU was for at least 25 trained nurses and three nursing assistants during the morning shift, 26 nurses and two nursing assistants during the evening shift and 26 nurses and one nursing assistant during the night.
- There were vacancies for four whole time equivalent band five nurses and two band six nurses in the CTCCU. The CTCCU matron told us the three band five nurses had recently been promoted to fill the existing band six nurse vacancies and there were also no band seven nurse vacancies. Recruitment for the band five nursing posts was ongoing with nine new recruits awaiting start dates and a further eight currently at interview stage. A number of newly appointed nurses that were undergoing induction were also working on the unit and these were supernumerary until they had completed their induction.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. Where agency staff were used, the trust carried out checks to ensure that they had the right level of training in critical care. External agency staff use in the AICU and CTCCU did not exceed levels recommended by ICS guidelines (less than 20% agency staff on any one shift).
- The critical care outreach team included six band seven nurses, with two nurses on duty during the morning shift (7:30am to 4:30pm) and one nurse during the evening shift (12:00pm to 8:30pm).

Medical staffing

- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- The AICU and CTCCU each had a designated lead consultant for intensive care as set out in the ICS standards.
- The consultant to patient ratio did not exceed one to eight during weekdays and one to fifteen during out-of-hours service in line with ICS standards.
- There were 14 critical care consultants committed to the AICU. The consultants were also responsible for any critical care patients based in the burns unit. The AICU lead consultant told us there were no medical staff vacancies within the AICU.
- During weekdays, at least two consultants were based on the AICU between 8am and 6pm with one consultant during the night until 8am. During the weekends there was at least one on-call consultant covering the unit over a 24-hour period.
- During weekdays, the AICU was staffed with at least five trainee doctors between 8am and 6pm and at least two trainee doctors during the night shift between 8pm and 8:30am. During weekends, there were at least three doctors covering the unit between 8am and 8:30pm and two trainee doctors during the night. There was at least one airway-trained doctor on the unit at all times.
- There were 15 full time and two part-time critical care consultants committed to the CTCCU with a rota divided into two sections; one covering Monday to Thursday and the second covering Friday to Monday. During weekdays, at least three consultants were based on the unit between 8am and 6pm. During out of hours and weekends there were at least two on-call consultants. There were at least two trainee doctors covering the CTCCU at all times.
- The CTCCU lead consultant told us there were two consultant vacancies and funding had been agreed to recruit to these posts.
- Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handovers.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the critical care services, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident.

Critical care

- Records showed 95% of CTCCU staff and 78% of AICU staff had completed basic life support training.

Are critical care services effective?

Good

The service provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The service performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.

ICNARC data up to September 2015 showed the AICU performed within expected levels for unit acquired infections, hospital mortality, non-clinical transfers out and for unplanned readmissions within 48 hours and post 48 hours. This meant the majority of patients had a positive outcome following their care and treatment.

The ICNARC data also showed that patient length of stay was higher than expected levels. However, this was mainly due to critically ill patients from the burns unit and the weaning of ECMO patients that required a longer time for recovery.

Patients received care and treatment by multidisciplinary staff that worked well as a team. A consultant-led ward round took place twice a day on each critical care unit with input from nursing, pharmacy and physiotherapy. A daily microbiologist ward round also took place separately on each unit. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE), National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations as well as guidance published by the relevant medical bodies such as the Royal Colleges and British Medical Association.
- Staff carried out a daily assessment of delirium (acute confusion) in patients using the 'Confusion Assessment Method for intensive care' (CAM-ICU) guidelines.
- The critical care services participated in quality audits as part of risk over network (RICON) project in collaboration with the Greater Manchester Critical Care Network. The service participated in six quality audits, including medicine safety, communication, patient access, lung protective ventilation and airway safety.
- The cardiothoracic unit's extracorporeal membrane oxygenation (ECMO) services were registered with and collaborated with the Extracorporeal Life Support Organization (ELSO).
- Findings from clinical audits were reviewed for any changes to guidance and the impact that it would have on practice was discussed during departmental audit meetings that took place every two months. Audit findings were also shared with the critical care network and ELSO to look for improvements to the service.

Pain relief

- The critical care staff had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant. Staff carried out hourly checks using the Richmond Agitation-Sedation Scale (RASS), which is a medical scale used to measure the agitation or sedation level of a patient.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice and treatment if required.
- Patient records showed that patients that required pain relief were treated in a way that met their needs and reduced discomfort. The patients and relatives we spoke with also told us their pain symptoms were effectively managed.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements. Where patients were identified as 'at risk', there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff to ensure patient safety. A dietician was available on the units three days per week and was available to participate in daily ward rounds if needed. There were protocols for initiating appropriate nutritional support out of hours.

Critical care

Patient outcomes

- ICNARC data up to September 2015 showed the AICU performed within expected levels for unit acquired infections, hospital mortality, non-clinical transfers out and for unplanned readmissions within 48 hours and post 48 hours.
- The ICNARC data also showed the unit performed worse when compared to similar units nationally for patient length of stay. The AICU lead consultant told us the length of stay rates were higher than expected levels due to critically ill patients from the burns unit and the weaning of ECMO patients that required a longer time for recovery.
- The CTCCU did not participate in the ICNARC audit. The CTCCU lead consultant told us they planned to participate in the ICNARC audit in the future but there was no formal plan or timelines for implementation for this at the time of our inspection.
- Records for the CTCCU between January 2015 and December 2015 showed: -
  - There were 102 patient deaths on the unit (crude mortality rate of 5.85%).
  - The average patient length of stay per month ranged between 3.5 days and 4.6 days.
  - The proportion of discharged patients readmitted to the unit within 48 hours per month ranged between 3% and 8%.

Competent staff

- The critical care units had practice educators that oversaw training processes and carried out competency assessments based on national critical care competency guidelines.
- Newly appointed staff had an induction and their competency was assessed over a period of eight weeks before working unsupervised. During the induction period, the new starters were supernumerary (i.e. in addition to the staffing establishment). This was followed by further training during the first year after which they were placed on a post graduate critical care course.
- Staff told us they routinely received supervision and annual appraisals. Records showed the annual appraisal completion rate in the AICU was 86% for medical staff, 88% for nursing staff and 100% for support staff. The appraisal rate in the CTCCU was 90% for medical staff, 99% for nursing staff and 100% for support staff. This meant the majority of staff had completed their annual appraisals and achieved the trust target for 85% appraisal completion.
- Records showed that 63% of nursing staff in the AICU and 58% of nursing staff in the CTCCU had completed the post registration award in critical care nursing, which exceeded the ICS standard for at least 50% of staff to have completed the training.
- Records showed all eligible medical staff in the critical care services that had reached their revalidation date had been reviewed and recommended for revalidation with the General Medical Council.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within both critical care units. Staff handover meetings took place during shift changes and 'safety huddles' were carried out twice daily to ensure all staff had up-to-date information about risks and concerns.
- A consultant-led ward round took place twice a day on each unit with input from nursing, pharmacy and physiotherapy. A daily microbiologist ward round also took place separately on each unit. The nursing staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Staff told us they received good support from pharmacists, dieticians and physiotherapists as well as diagnostic support such as for x-rays and scans.
- The critical care outreach team was supported by a consultant who carried out follow up clinics for patients that had a long term stay in critical care. Patients were offered a follow up appointment six weeks after their discharge.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients' needs.

Critical care

- We found that sufficient out-of-hours medical cover was provided to patients by junior and middle grade doctors as well as on-site and on-call consultant cover. Patients admitted to critical care were seen daily by a consultant.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. Physiotherapy and pharmacy support was available on the unit during the day on Saturdays and Sundays.
- Staff told us they received good support outside normal working hours and at weekends.

Access to information

- Staff used paper based patient records that contained detailed patient information from arrival to the critical care unit through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.
- Staff told us the information about patients they cared for was easily accessible. However, staff told us they experienced difficulties when using trust-wide electronic systems such as for blood analysis requests and printing out specimen labels. Staff told us the IT systems were often slow and this meant these activities sometimes took longer. There was an ongoing improvement programme across the trust to improve the IT systems in order to address this.
- Notice boards were used to highlight where patients were located within the unit and to identify high risk patients such as patients with an infection or those identified as living with dementia. The notice boards also highlighted when pharmacist reviews had taken place.
- We saw that information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the trusts intranet.

Consent and Mental Capacity Act

- Staff understood how to seek consent from patients and understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Records showed 93% of critical care staff had completed mental capacity act training.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity to make an informed decision about their treatment. We looked at one patient record where a deprivation of liberties safeguards application had been made and this had been completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

Are critical care services caring?

Good

Patients and their relatives spoke positively about the care and treatment provided. They told us they were treated with dignity, empathy and compassion. Staff ensured patients or their relatives were involved in their care and relatives were able to arrange face to face meetings with a consultant if they had any queries or concerns.

Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.

Patients and their relatives told us the staff supported them with their emotional and spiritual needs. They told us they were able to voice any concerns or anxieties. Each unit had facilities to provide overnight accommodation for the relatives of patients. Relatives staying overnight were also provided with comfort packs that included items such as toothpaste and a toothbrush. Relatives were routinely offered a bereavement follow up support six weeks after the death of a patient.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. The patients we saw were well positioned and their dignity was maintained.

Critical care

- We spoke with four patients and the relatives of four additional patients. They told us the staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that patient dignity was maintained. The comments received included “staff are fantastic” and “best hospital I’ve been in so far”.
- We observed staff providing care in a respectful manner. We saw that patients’ bed curtains were drawn and staff conversations about patient care and treatment were conducted discreetly to maintain privacy and confidentiality.

Understanding and involvement of patients and those close to them

- When necessary, relatives could arrange face to face meetings with a consultant. Patient relatives spoke positively about the communication and support received from staff. They told us they had been kept fully updated and were given opportunities to have all their questions answered. The comments received included “staff clearly explain things” and “can phone anytime for an update”.
- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.
- Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition. One patient told us they were looking forward to reading their diary after they were discharged because they could not fully remember some of the time they had spent on the CTCCU.

Emotional support

- Patients and relatives spoke positively about the support given to them by staff. They told us they were able to voice any concerns or anxieties. The comments received included "cant praise the nurses enough, they keep me positive" and "I was scared but the nurses and doctors have been wonderful, caring and I'm grateful for what they are doing".
- Staff were able to provide overnight accommodation for relatives of patients. The AICU had two relatives rooms that could accommodate up to four people. These rooms were equipped with televisions and ensuite bathrooms. The CTCCU also had a relatives room where overnight accommodation could be provided.
- The relatives of one patient spoke positively about the facilities provided and told us they were able to stay on the AICU unit 24 hours per day for five days during a critical phase in the patients stay in critical care. Relatives staying overnight were also provided with comfort packs that included items such as toothpaste and a toothbrush.
- Staff could seek support from the palliative care team if a patient required end of life care. Patient and relative handbooks provided information about bereavement, counselling, chaplaincy and spiritual support services that were available.
- There was a trust-wide bereavement service in place to support patients, relatives or staff. Relatives were routinely offered a bereavement follow up support six weeks after the death of a patient.

Are critical care services responsive?

Requires improvement

There was insufficient capacity within the critical care services which meant patients were not always admitted promptly to receive the right level of care. NHS England data showed bed occupancy levels between May 2013 and March 2015 were consistently higher than the England average. The acute intensive care unit (AICU) reported occupancy levels of 100% on five occasions between March 2014 and March 2015. The cardiothoracic critical care unit (CTCCU) reported occupancy levels of 100% or above on six occasions during 2015.

The high bed occupancy levels in the critical care services meant operations were cancelled due to the lack of available critical care beds. There were 41 operations cancelled due to a lack of AICU beds being available and 113 operations cancelled due to no CTCCU beds being available between January 2015 and December 2015.

As part of the trust’s escalation policy, patients were transferred to the main theatres recovery area when there were no critical care beds available. There had been 59

occurrences of patients being nursed overnight in theatre recovery from April 2015 to October 2015. Patients kept overnight in recovery were assessed by critical care consultants. However, they were cared for by recovery nurses that had not completed all the relevant competencies to treat critically ill patients. There were plans in place to provide training for recovery staff by the end of March 2016.

Patients were not always discharged from critical care in a timely manner due a lack of available ward beds and capacity constraints across the trust. ICNARC data up to September 2015 showed the number of reported delayed discharges (within and greater than four hours) was worse than other comparable units nationally. The data showed the delayed discharges were consistently 10% to 20% above the average since January 2013.

The critical care services had implemented a new patient flow policy since December 2015 and this was designed to improve access to critical care and reduce delayed discharges. There were plans in place to open a two-bedded long term ventilation and weaning unit by July 2016 and the introduction of this service was expected to free up capacity for up to two beds in the AICU to improve patient access to the unit

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There had only been two complaints relating to the AICU and two complaints in relation to the CTCCU during the past 12 months and these were addressed in a timely manner.

Service planning and delivery to meet the needs of local people

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was daily involvement by the matrons to address and manage these risks.
- There were daily meetings with the bed management team so patient flow could be maintained and to identify and resolve any issues relating to the admission or discharge of patients.
- There were 2957 admissions to critical care services at the hospital and 2953 discharges between April 2014 and March 2015.
- The critical care services applied a flexible approach when admitting patients and staffing levels were adjusted depending on the level of patient acuity. Patients could be transferred to the CTCCU or the burns unit Intensive care unit during periods of high demand. At least one bed was kept available in the burns unit to allow for the emergency admission of critically ill burns patients.
- The critical care services were provided for adults over the age of 16 years. The CTCCU matron told us there were two instances where children under the age of 16 were admitted to the cardiothoracic critical care unit due their complex medical needs. In both instances the staff were supported by paediatric-trained nurses and the patients were managed by paediatricians to ensure these patients received appropriate care.

Meeting people's individual needs

- Information leaflets about the services were readily available. We did not see written information readily available in different languages or other formats, such as braille. However, staff told us these could be provided upon request. Patients and relatives were also provided with handbooks which included information about the available services.
- Staff could access a language interpreter if needed. A telephone interpreter service was available 24 hours per day.
- Staff received mandatory training in dementia awareness and learning disability awareness. The unit also had dementia link nurses in place that had received additional training and could provide advice and support for staff on the unit. Staff could also contact the trust-wide safeguarding team for advice and support around caring for patients living with dementia or a learning disability.
- Staff used a 'forget me not' document for patients living with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. Staff told us the additional records were designed to accompany the patients throughout their hospital stay.
- There were defined visiting hours for relatives. However, relatives could arrange to visit patients at any time during the day depending on the patient's condition.
- Staff could access appropriate equipment to support the moving and handling of bariatric patients (patients with obesity) admitted to the critical care units.

Access and flow

Critical care

- Patients could be admitted to the critical care services via the emergency department or from operating theatres, wards and departments across the trust. The critical care services operated a closed admission policy with all admissions needing to be discussed between the referring team and the critical care consultant.
- The trust did not routinely collate data to show the proportion of patients that were admitted within four hours of referral. However, patients admitted to the AICU and CTCCU were assessed by a consultant within 12 hours of admission in accordance with ICS guidelines.
- NHS England data showed bed occupancy levels between May 2013 and March 2015 were consistently higher than the England average of 80%. The AICU reported occupancy levels of 100% on five occasions between March 2014 and March 2015. Bed occupancy rates above 85% can increase the risk of harm to patients.
- Trust records showed that monthly bed occupancy rates in the CTCCU ranged between 93% and 105% between January 2015 and December 2015. This included six occasions where occupancy levels exceeded 100%. The occupancy levels were based on 26 available critical care beds. However, the CTCCU had five additional beds on the unit that were made available when needed.
- ICNARC data up to September 2015 showed the number of patients transferred out for non-clinical reasons in the AICU was within expected levels and consistently lower (better) than other comparable units nationally.
- ICNARC data also showed the number of reported delayed discharges and delayed discharges greater than four hours was worse than other comparable units nationally. The data showed the delayed discharges were consistently 10% to 20% above the average since January 2013.
- Records for the AICU showed there had been 127 delayed discharges between April 2014 and March 2015. Records for the CTCCU showed there had been 62 delayed discharges between April 2014 and March 2015.
- The delayed discharges were mostly due a lack of available ward beds and capacity constraints across the trust which meant staff were unable to transfer patients after the decision to discharge from critical care had been made.
- The high bed occupancy levels in the critical care services meant operations were cancelled due to the lack of available critical care beds. There were 41 operations cancelled due to no AICU beds being available between January 2015 and December 2015. There were 113 operations cancelled due to no CTCCU beds being available during this period.
- As part of the trust's escalation policy, patients were transferred to the main theatres recovery area when there were no critical care beds available. There had been 59 occurrences of patients being nursed overnight in theatre recovery from April 2015 to October 2015. This included 27 long-term ventilated patients.
- Patients kept in the theatre recovery area overnight were assessed by a critical care consultant and managed by the on-call anaesthetist whilst in theatre recovery. The critical care outreach team also provided support for these patients but this support was not available overnight.
- There were no incidents relating to the safety of patients kept in theatre recovery overnight. Specialist equipment such as ventilators and drug infusion equipment were available in the recovery area. The patients were cared for by recovery nurses that were trained in airways management. However, these nurses did not have all the relevant competencies needed for managing critical care patients in the longer term.
- The theatre recovery and critical care teams had developed a plan which listed actions to minimise the risks to patients kept overnight in theatre recovery. This included developing an 'admission criteria' policy that was due to be finalised during February 2016. The action plan also identified additional critical care training for recovery staff to be delivered by the end of March 2016 and to review the feasibility of 24 hour critical care outreach service by June 2016.
- The AICU lead consultant told us that since January 2016, they had started to record the time taken to admit patients to allow the service to measure the four hour admission performance indicator more accurately.
- The critical care services had implemented a new patient flow policy since December 2015 and this was designed to improve access to critical care and reduce delayed discharges.
- The hospital planned to open a long term ventilation and weaning unit by July 2016 and funding had been approved for two mechanical ventilation weaning beds to support the Greater Manchester Critical Care

Network. The AICU lead consultant told us the introduction of this service would free up capacity for up to two beds in the AICU to improve patient access to the unit.

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care unit and included contact details for the Patient Advice and Liaison Service (PALS). The patient's relatives we spoke with were aware of how to raise complaints.
- The AICU and CTCCU matrons were responsible for reviewing and investigating complaints. Information about complaints was discussed during daily 'safety huddles' and monthly team meetings to raise staff awareness and aid future learning.
- The hospital's complaint policy stated that formal complaints would be acknowledged within three working days and investigated and responded to within 25 working days for routine complaints and up to 40 days for complex complaints that required detailed investigation or root cause analysis.
- Records showed there were only two formal complaints relating to the AICU and two complaints relating to the CTCCU raised over the past 12 months and these were appropriately investigated and responded to in a timely manner.

Are critical care services well-led?

Good

The trust vision and values had been cascaded across the critical care services and staff had a clear understanding of what these involved. Key risks to the services, audit findings and quality and performance was monitored though routine departmental and clinical governance meetings.

There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the critical care services and the level of support they received from their managers. The management team understood the key risks and challenges to the service and how to resolve these.

Vision and strategy for this service

- The trust vision was "To become a top 10 NHS provider in the country." The trust mission statement was ""To improve the health and quality of life for all our patients by building an organisation that attracts, develops and retains great people."
- This was underpinned by a set of five core 'PEOPLE' values and strategic objectives that were based on "patient first", "excellence", "one team", "being open" and "leadership".
- The trust vision, values and objectives had been cascaded to staff across the critical care services and staff had a clear understanding of what these involved.
- The acute intensive care unit (AICU) strategy plan 2015/16 outlined key objectives relating to improving capacity and patient flow, the creation of a long-term ventilation and weaning unit and a focus on research and innovation in clinical areas of experience in respiratory failure, pneumonia and infection.
- The strategic vision for the cardiothoracic critical care unit (CTCCU) outlined plans to further enhance and develop the extracorporeal membrane oxygenation (ECMO) treatments provided by the service.

Governance, risk management and quality measurement

- There were monthly departmental unit meetings held within the AICU and CTCCU. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- There were routine staff meetings on each unit to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. Risks relating to the critical care services were incorporated into a local departmental risk register and divisional risk register separately within the AICU and CTCCU. These were reviewed and updated during monthly or bi-monthly directorate level clinical governance meetings.
- We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Audit meetings were held every three months in both units. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards and newsletters.

Critical care

- The critical care services were routinely peer reviewed through the Greater Manchester Critical Care Network to assess compliance against national critical care standards. The AICU and CTCCU were both reviewed during May 2015 and action plans were in place to address the findings from the peer audits.

Leadership of service

- The AICU was incorporated into the clinical support services division and the CTCCU was part of the cardiothoracic directorate within the scheduled care division.
- There were clearly defined and visible leadership roles across both critical care units. There was a designated lead consultant for intensive care that oversaw the critical care services within each unit. The nursing staff were managed by a supernumerary lead nurse on each shift, who reported to a matron within their unit. The AICU matron had been in post since October 2015.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were proud, highly motivated and positive about their work. They described the senior nursing and medical staff as approachable, visible and able to provide them with good support. Staff told us they were confident they could raise concerns with their managers and they felt their concerns were listened to.
- Staff told us there was a friendly and open culture. Trainee medical and nursing staff told us that they felt well supported.
- Records showed overall sickness levels for staff across the AICU and CTCCU were around 4% between May 2015 and January 2016. The sickness levels were within the expected trust target (4.4%) and in line with national averages during this period.
- The average staff turnover rate was 18% in AICU and 19% in CTCCU between May 2015 and January 2016. This was greater (worse) than the trust target of 13%. The matrons for AICU and CTCCU told us this was mainly due to a high turnover of band 5 nurses. There was an on-going recruitment programme for band five nurses to account for the turnover rates.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Patients that had previously stayed on the unit and their relatives were invited to attend a follow up appointment and share their experiences.
- The critical care services did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment.
- Staff sought feedback from patients and their relatives by asking them to complete a feedback survey. The survey covered key areas such as quality of care, patient involvement, management of anxiety and whether they would recommend the services to others.
- The surveys for December 2015 were displayed in the units and were based on six patient responses in the AICU and 10 responses in the CTCCU. The survey results showed that feedback was mostly positive (over 90%) across all areas covered by the survey.
- The information from the surveys was used to look for improvements to the services. For example, the AICU survey highlighted patients and relatives could not distinguish the different staff groups. This was cascaded to all the staff and staff were instructed to wear identification badges and formally introduce themselves to patients and their families.
- A review of data from the CQC's adult inpatient survey 2014 showed that the trust was about the same compared with other trusts for all 10 sections, based on 362 responses received from patients.

Staff engagement

- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings. The trust also engaged with staff via newsletters and through other general information and correspondence that was displayed on notice boards.
- Staff across the critical care services spoke positively about attending a listening event held by the chief operating officer during the past year.
- The trust had eight positive findings within the NHS staff survey of 2014. There were two negative findings in relation to the overall survey response rate and the proportion of staff reporting errors, near misses or incidents witnessed in the last month. The remaining 22 questions were within expected levels when compared to other trusts.

Critical care

- There was an action plan in place to improve areas such as communication and reporting and governance processes to improve reporting of incidents.
- The trust also carried out staff 'pulse' surveys every three months. Results from the October 2015 to December 2015 pulse survey showed the responses from the critical care and cardiothoracic teams were mostly positive.

Innovation, improvement and sustainability

- The AICU and CTCCU had completed a ward accreditation based on a number of nursing standards with an achievement rating of bronze, silver or gold. Both units had achieved a silver rating, which meant the critical care services were meeting the majority of the trusts ward accreditation standards.
- The critical care services carried out collaborative work with the Greater Manchester Critical Care Network. There was participation in quality audits, such as the ventilator care bundle audits. This information was shared with the care network to look for improvements to the service.
- There was involvement in a number of improvement projects and research trials to improve the service provided. This included the Leopards clinical trial on Levosimendan for the prevention of acute organ dysfunction in sepsis and protective ventilation with veno-venous lung assist in respiratory failure (The REST Study). The services also recently won a 75,000 award to investigate quality improvements around tracheostomy care.
- The CTCCU planned to start one of the first fully-fledged Oxygenation during Cardio-Pulmonary Resuscitation (ECMO-CPR) services in the country to help young, previously fit and healthy people survive a cardiac arrest.
- The critical care matrons and lead consultants told us the devolution of Manchester proposals could have an impact on services in the future but they felt confident about their ability to deliver specialist critical care services. The hospital was one of the few hospitals in the country that provided a specialist ECMO service along with transplant services and ventricular assist device (VAD) surgery within the same hospital.

Maternity and gynaecology

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

Information about the service

The University Hospital of South Manchester NHS Foundation Trust delivers all maternity and gynaecology in-patient services from Wythenshawe Hospital. In addition, there are antenatal clinics and parent craft classes available at local schools, children centres and GP surgeries, and at Trafford General and Withington Community Hospitals.

Gynaecology services are delivered from the Women's Health Suite based on ward F16 and from outpatient clinics. These services include an Early Pregnancy Unit which is open 08.30 to 17:00 Monday to Friday, for non-emergency care in the first 16 weeks of pregnancy. There is also a Gynaecology Assessment Unit for women with urgent gynaecology problems who don't need to be seen in the emergency department (ED). There is a termination of pregnancy service for where a fetal abnormality has been identified. Where the pregnancy is less than 16 weeks gestation, a termination would be conducted in Gynaecology. Where the pregnancy is more than 16 weeks gestation, the termination would be conducted in maternity. In 2014/15, 147 medical and 114 surgical abortions were carried out at the trust.

There is a Colposcopy Clinic which supports the national screening programme and is for women who have received an abnormal smear test. There is also a Hysteroscopy Clinic, which is an examination of the lining of the womb required for patients with post-menopausal or unexplained bleeding. There is also a Hycosy Clinic for women with fertility problems who require an examination of their fallopian tubes. Finally, there is a rapid access clinic for women with serious gynaecology problems. Ultrasound scanning is available on the Women's Health Suite.

The trust supported 4421 births between 1 January and 31 December 2015, with an average of 368 births a month. This represented a 4.6% increase on the year before.

The maternity service has a total of 64 maternity beds, with only half occupied most of the time. This bed occupancy rate is significantly lower than the average rate across trusts in England. The service consists of an obstetric consultant-led Delivery Suite with 12 delivery rooms, ten with en-suite facilities. All of the delivery rooms have adjustable delivery beds and one has a birthing pool which is used for pain relief. There is a wireless telemetry system which allows women to move around in labour whilst continuing with fetal monitoring. There are two operating theatres.

Alongside the Delivery Suite there is a midwife-led unit which is available for women whose pregnancy has been assessed as 'low risk'. There are five delivery rooms in the Birthing Centre and all have birthing pools had en-suite facilities. The rooms do not have delivery beds but have flexible birthing couches, large mats and bean bags for active labour. The rooms are spacious and set up to offer the sort of environment a women might have during a home birth, with comfy chairs, coffee table and tea and coffee making facilities. There is a large lava lamp in each room and no limitations placed by the trust on the number of birthing partners that a woman may have. Equipment in these rooms is kept to a minimum but there is a sonicaid

for monitoring the fetal heartbeat, baby weighing scales and Entonox for pain relief. If more support is required, and if there is an emergency, there is a call bell and there would be a transfer to the Delivery Suite.

The postnatal ward (C2) has 29 beds arranged in two and four bedded bays and in single rooms with en-suite facilities. The single rooms can be hired privately. There is an area on the ward that is for 'transitional care'. That is, care for babies who may not need to go to the local neonatal unit (level two), but do require a little extra support.

There is a telephone triage service which operates 24 hours a day, seven days a week. This is for women with a pregnancy over 16 weeks gestation with concerns or difficulties such as, high maternal blood pressure or reduced fetal movement. It is a telephone service initially but with bed facilities for monitoring and consultation. There is also a Day Assessment Unit which is for women with more persistent problems in pregnancy that require closer monitoring. The service provides a scanning service and is available by appointment and through clinics. There is a fetal screening service for women between 11 and 13 weeks of pregnancy.

There is an Antenatal ward (C3) which is a specialist ward for women experiencing difficulty in pregnancy, usually from 20 weeks gestation, requiring hospital care. There are 17 beds, which included one cubicle with three beds, two cubicles with four beds and six single rooms. There is also a bereavement room and facilities.

There are five teams of community midwives who offer antenatal clinics and visit women at home postnatally. They are supported by a team of midwives who offer advice and guidance and support vulnerable women with specialist services for mental health issues, domestic violence and safeguarding. The service also supports pregnant women from a local prison.

We visited all areas of maternity and gynaecology services and spoke with more than 60 members of staff, some on an individual basis and others in joint meetings, handover sessions and focus groups. This included staff of all grades including midwives, doctors, consultant obstetricians, domestics, maternity care assistants, receptionists, ward managers and members of the senior management team. We spoke with nine patients from both gynaecology and maternity and we looked in detail at eight sets of patient notes. We made observations about the provision of care, staff interactions, the availability of equipment and the environment. We reviewed written material such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements.

Maternity and gynaecology

Summary of findings

Overall we rated maternity services as requires improvement because:

There had been a backlog of incidents requiring investigation and a lack of clinical engagement in the investigation process. At the time of our inspection, the service was receiving reports from the investigation of incidents that had occurred 20 months ago. This meant that there was a significant delay in the service understanding and sharing the learning arising from these incidents and a delay in making improvements to enhance the safety of the service as a result. We found a lack of incident reporting and a downward trend in number of incidents reported in a 12 month period.

There had been a long standing concern within maternity services in terms of safeguarding children's level three training. At the time of the inspection average compliance for the service was 79%, with obstetric medical staff at 55% compliance. There was an action plan in place which was having little effect in raising compliance levels.

Mandatory training compliance at 84.8% was slightly worse than the trust target for maternity services. Within gynaecology services, mandatory training figures ranged between 60% (information governance) and 100%. However, community midwives experienced difficulties in attending mandatory training due to capacity issues and they were completing training in their own time.

Staff expressed their concerns in terms of the senior medical rota on delivery suite. Staff felt that the management of patient risk was fragmented and there was little continuity of care due to the rota being split into four separate shifts. We were informed this could lead to care plans changing more frequently and clinicians delaying making a decision until the next doctor took over.

The ratio of midwives to births within the service at the time of our visit was one midwife to every 31 births, which was worse than the England average and trust target. The service had not been compliant with this target since February 2015. However, senior staff and midwifes confirmed there was one to one care in labour in the birth centre and on the delivery suite. In addition, we found discrepancy in weekly consultant cover data within the information we reviewed and discussion with senior staff, including clinical lead.

The smooth flow of patients on ward F16 was interrupted by limited access to sonography. The shortage of scanning sessions available in the early pregnancy assessment unit led to unnecessary admissions to the ward.

There was a lack of engagement and leadership from senior clinicians within the service. This lack of engagement had resulted in a significant delay in investigating incidents and reviewing and updating clinical guidance.

Staff raised concerns in relation to having no involvement in risk management meetings or in the governance process other than reporting incidents. Staff also told us they did not receive feedback after reporting an incident.

A review of the services and of medical staffing in June 2015, concluded 'ineffective clinical leadership had resulted in a fragmented disorganised service with wide variation in practice, with no cohesion between the senior clinicians and no significant professional development or succession planning'.

The unit governance information and incident update had not been distributed since June 2015 and there was no group for reviewing and updating clinical guidelines. We subsequently saw no evidence of lessons learned being shared with staff.

However:

Records relating to the care of each woman were completed accurately and safeguarding procedures were operating well. There was good individual risk assessment and care planning.

Compliance with mandatory training was good and was monitored closely. Women reported feeling safe and confident in the skills of midwives and doctors.

We found a good standard of cleanliness in all areas inspected. There was evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning.

Maternity and gynaecology

Infection control measures were in place and compliance was monitored regularly through a ward accreditation framework. Medicines were stored and managed appropriately.

The delivery suite had been recently refurbished and provided with modern equipment which was kept clean and ready for use.

Staff working in maternity and gynaecology services offered evidence based care and treatment based on national guidance and standards. However, some of the local guidance was out of date.

Multi-disciplinary working was good both within the service and with agency partners. Pain management was available and the service was supporting the development of new approaches.

Parents were receiving caring services. Staff also took care to protect the dignity and privacy of women in all areas of the service and there was good support for women and their partners experiencing pregnancy loss. Partners were made to feel welcome and involved in the pregnancy, labour and birth.

Specialist support was available for young pregnant women, those with alcohol and drug addictions and women with mental health issues. Improvement plans were linked directly to feedback from women. Careful service planning was improving responsiveness through more specialist clinics and specialist pathways.

People could raise concerns and complaints and be confident this would be investigated and responded to appropriately. There was evidence the trust used complaints to improve the services.

A rapid access clinic had been introduced for menstrual disorders and post-menopausal bleeding to meet demand and allow for the development of innovative out-patient treatments such as microwave endometrial ablation (Endometrial ablation is a surgical treatment for women who have heavy periods) and hysteroscopy sterilisation (permanent, less-invasive surgical sterilization procedure for women).

The bereavement midwife had been nominated for the national Butterfly awards two years running. These are awards celebrating survivors and champions of baby loss. The bereavement midwife was also runner up in the Royal College of Midwifery awards for her work providing bereavement support.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated the service as 'requires improvement' for safety. This was because there had been a backlog of incidents requiring investigation and a lack of clinical engagement in the investigation process. When we visited, the service was receiving reports from the investigation of incidents that had occurred 20 months ago. This meant there was a significant delay in the service understanding and sharing the learning arising from these incidents and a delay in making improvements to enhance the safety of the service as a result. We found a lack of incident reporting and a downward trend in number of incidents reported in a 12 month period.

There had been a long standing concern within maternity services in terms of safeguarding children's level three training. At the time of the inspection average compliance for the service was 79%, with obstetric medical staff at 55% compliance. There was an action plan in place which was having little effect in raising compliance levels.

Mandatory training compliance at 84.8% was slightly worse than the trust target for maternity services. Within gynaecology services, mandatory training figures ranged between 60% (information governance) and 100%. However, community midwives experienced difficulties in attending mandatory training due to capacity issues and they were completing training in their own time.

Staff expressed their concerns in terms of the senior medical rota on delivery suite. Staff felt that the management of patient risk was fragmented and there was little continuity of care due to the rota being split into four separate shifts. We were informed this could lead to care plans changing more frequently and clinicians delaying making a decision until the next doctor took over.

The ratio of midwives to births within the service at the time of our visit was one midwife to every 31 births, which was worse than the England average and trust target. The service had not been compliant with this target since February 2015. However, senior staff and midwifes confirmed there was one to one care in labour in the birth centre and on the delivery suite. In addition, we found discrepancy in weekly consultant cover data within the information we reviewed and discussion with senior staff, including clinical lead.

The service had effective systems in place for reporting incidents and staff were confident about reporting incidents routinely. Infection control measures were in place and compliance was monitored regularly through a ward accreditation framework. Medicines were stored and managed appropriately.

The delivery suite had been recently refurbished and provided with modern equipment which was kept clean and ready for use.

Records relating to the care of each woman were completed accurately and safeguarding procedures were operating well. There was good individual risk assessment and care planning.

Action was being taken to return midwifery staffing levels to the required levels and was using an appropriate workforce planning and acuity tool. Following a number of retirements from the service, skill mix issues were being reviewed and providing opportunities for promotion within the service.

Compliance with mandatory training was good and was monitored closely. Women reported feeling safe and confident in the skills of midwives and doctors.

Incidents

- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- In the 12 month period between November 2014 and October 2015 no never events were reported in the maternity and gynaecology services. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.
- Between November 2014 and October 2015, there were 840 incidents in total in maternity and gynaecology services, 525 of which resulted in no harm. A further 307 resulted in low harm and five in moderate harm. There was a downward trend in the number of reported incidents during 2015, with 85 reported in January and just 50 in October 2015.

- The most commonly reported incident category was 'Access, Admission, Transfer, Discharge.' The second most commonly reported category was treatment-procedure incidents. Incidents were reported in a timely way with 94% of incidents being reported within 30 days.
- Between November 2014 and October 2015 one serious incident was reported to have occurred on the gynaecology ward of the Women's Health Suite, and two stillbirths occurred within the maternity unit. We reviewed the investigation report for the serious incident and observed that it had been investigated appropriately and an action plan was in place. We requested notes from the safety huddles where lessons learned from this serious incident were discussed but did not receive them.
- We reviewed the investigation report of one of the stillbirths that occurred in 2015. We found that the trust had completed a rigorous investigation and had commissioned an independent review of the cardotacographic (CTG) (fetal heart trace) output by an external consultant obstetrician. This investigation and the areas of learning identified were reported in detail in the June 2015 edition of the 'Unit Governance Information and Incident Updates'. This was a bulletin distributed, up until June 2015, to staff in the maternity service and produced by the Governance and Risk Management Midwife. Areas identified for learning included new guidance on when to involve consultants in the management of the induction of labour, using the 'fresh eyes' review of CTG forms and when and how to perform a clinical handover.
- Both of the serious investigation reports included the patient and those close to them in the discussion of the events, in the cause of the incident and in the learning from the incident. In both the cases we looked at, an apology was offered and the patient was invited to engage in the investigation. An investigation report was shared with the patient and those close to them. This demonstrated an open and honest approach by the service and a willingness to learn from and share any lessons from incidents.
- We attended the Labour Ward Forum meeting on 27 January 2016 attended by midwives, matrons, consultants, anaesthetists, pharmacist and registrars. They discussed the progress of incident investigations in the obstetrics report for December 2015. We noted that, from the agenda item, 'recently completed serious incident investigation reports and root cause analysis' serious incidents that were fed back to the meeting related to incidents that had occurred in April and May 2014. We saw no evidence of learning from recent incidents.
- There were other methods employed within the maternity service to share learning from incidents and complaints. For example, the Governance and Risk Midwife shared lessons at the monthly Labour Ward Forum and at the Clinical Governance meetings. A senior midwife wrote to all ward managers with the weekly 'hotspots'. These were issues arising from incidents, investigations and complaints and themes from the labour ward forum, governance meetings and the ward accreditation process.
- We found that not all incidents had been reported. This included admissions to the neonatal unit from maternity. The data presented to the labour ward forum in January 2016 showed that only four of the admissions from December 2015 were reported compared to the 16 that were actually admitted. This underreporting appeared to be occurring for several months across the service including the delivery suite, postnatal ward and the birth centre. It was not clear to us how the service was responding.
- Where investigations from incidents had taken place, the reports were thorough and the findings and action plans appropriate. However, we found that the effective, timely reporting and investigation of incidents in maternity had been interrupted by the lack of a clinical input since May 2015. This had led to a backlog of investigation reports and a discontinuation of established governance processes. In addition, there had been a change of personnel dealing with governance and risk in maternity and this had contributed to the disruption. We were made aware of action that was planned and being taken to resolve the situation.

Safety thermometer

- The gynaecology service participated in the NHS safety thermometer. This is a survey carried out in relation to all patients one day each month in respect to patient falls, catheters and urinary tract infections, pressure sores and venous thromboembolism (VTE)(formation of blood clots in the vein).

- Data from January to December 2015 showed an average of 97% harm free care. This included eight months of 100% harm free care; three months of more than 90% harm free care and one month of 87.5 % harm free care.
- The maternity service used a version of the NHS safety thermometer designed specifically to measure the potential harm that could occur commonly in that service. This measures harm from perineal or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar (an evaluation of a baby's condition at birth) score of less than seven at five minutes or those who are admitted to a neonatal unit. The data we saw covered the period from December 2014 to December 2015 and showed that all women had a 100% perception that their care was safe for every month apart from July 2015. Similarly, fewer than 5% of women had concerns about safety during labour and birth apart from July. Approximately 10% of women had an infection and fewer than 5% had third or fourth degree perineal trauma. Five percent of women, or fewer, said that they were left alone at a time that worried them.

  We did not see the data from these surveys displayed on the notice boards in gynecology or in the maternity service. The maternity service measured many of the same safety indicators, such as perineal tears, via the maternity dashboard and in the obstetrics report. This data was discussed at the labour ward forum and at the women's and children's directorate clinic governance committee.
- The performance report to the trust board for scheduled care for October 2015 showed the division achieved 96.5% harm free care against a target of 95%.

Cleanliness, infection control and hygiene

- We found a good standard of cleanliness in all areas inspected. There was evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. We found stickers on items of equipment indicating they were clean and ready for use.
- Women we spoke with on the gynaecology, antenatal and postnatal wards were pleased with the level of cleanliness.
- We observed staff, patients and visitors were using the hand sanitises on the wards and in the corridors.
- There were hot spot reminders on the delivery suite notice board reminding staff about infection prevention week. The notice identified that all trolleys were to have minimal stocking and staff were to adhere to aseptic techniques (methods designed to prevent contamination from microorganisms). We also saw a Zika virus alert and a reminder about 'high impact interventions' to prevent infections, such as, the prevention of surgical site infection.
- We reviewed an infection prevention audit for June 2015 which identified scores of over 90%, with 100% on ward F16 for the cleanliness of equipment shared by patients, for hand washing, use of alcohol hand gel and hand hygiene compliance.
- The infection prevention audit exceptions report for September 2015 listed the problem areas in each ward or unit where scores had been anything other than 100%. This identified, for example, that the antenatal ward (C2) had scored 99.2% for the cleanliness of the environment because the work station was dusty; similarly the postnatal ward (C3) had scored 99.3% because the curtains were soiled. The report listed the action to be taken and by whom.
- An audit had been conducted by the infection prevention team to establish whether there was compliance across the trust with the policy on Methicillin Resistant Staphylococcus Aureaus (MRSA). The results of the audit showed the policy was well embedded in relation to elective patients but that screening was taking between one and four days for patients who had arrived in an emergency. The target was for emergency patients to be screened for MRSA as soon as practical, but within one day.
- We reviewed other infection audits, for MRSA for example, where recommendations were made to improve the infection control practice. We also saw an audit on the quality of the documentation of known patient allergies to antibiotics and of the timeliness of response from microbiology to requests for clinical advice. This audit showed 98% of requests for clinical advice were responded to within the required standard of 30 minutes, where the data was available.
- The performance report to the trust board in, October 2015, for scheduled care stated, in the previous 12

months, the division had achieved 96.5% harm free care against a target of 95%. Over the same period, the division had reported no cases of MRSA and 15 cases of Clostridium Difficile (C.diff).

- The trust was using an annual ward accreditation scoring framework that included indicators on infection control and cleanliness and safety on each ward. The assessment involved asking questions of three members of staff, checking records and observation of the work on the ward.
- When we visited, the antenatal ward had achieved the gold award, the delivery suite had recently been awarded a silver accreditation for the second time and the birth centre, gynaecology and postnatal wards had achieved bronze accreditations. We spoke with several members of staff about this accreditation framework and they were all positive about it. One member of staff said, 'it helps to keep us on our toes'. This demonstrated that the trust had processes in place to maintain, monitor and raise standards in cleanliness, infection control and hygiene

Environment and equipment

- The delivery suite had recently been refurbished and provided a modern environment with up to date facilities and equipment. The space in the Women's Health Unit and on the gynaecology ward, however, was described by the Clinical Director as in need of a 'comprehensive redesign of the floor space on F16'. He also said that the service required an ultrasound scan machine, a stack system (monitor/light source) and a sufficient number of hysteroscopes (an endoscope that carries optical and light channels or fibers).
- When we attended the labour ward forum meeting on 27 January 2016, there was a discussion of progress with the scheduled refurbishment of the two obstetric theatres. We were told that the theatres were old and difficult to keep clean and safe. In addition, a discussion occurred in the meeting about the difficulties with controlling the temperature and lighting in these theatres and the possible risks to mothers and their newborn babies. The Clinical Director informed the meeting that it was hoped that funds for this work would be included in the capital budget for the next financial year.
- A risk identified on the risk register was the 'failure to provide a clean, safe and ergonomically sound environment for obstetric surgery, caused by the age of the infrastructure and fixed equipment contained in both maternity theatres'. The risk score had been increased from a score of eight to 12 (the highest risk rating) to take into account the control of theatre temperature and lighting issues that had been identified. We saw that refurbishment had been planned, but not implemented for 2014/15 and a review was planned for the end of the financial year 2015/16 to 'understand when this might take place'. In the meantime an action plan had been developed by the infection prevention team to offer maximum compliance with the environmental audit.
- We saw a response from the trust's Director of Estates and Facilities who confirmed that the maternity units would be unlikely to comply with the most recent, 2013, Health Building Note. This note consists of design principles and (non-statutory) guidance for buildings used in health care settings to enable effective cleaning and maintenance to take place and to maximise infection control.
- We saw the infection prevention audit exceptions report for September 2015 listing the problem areas in each ward or unit where scores had been anything other than 100%. The delivery suite theatre number two was included because the floors were old and there was chipped paint. We saw this was included in the report again in October 2015.
- We observed a safety huddle and observed that staff were made aware of any issues with equipment or the environment.
- We inspected equipment on delivery suite and found the daily logs were completed fully in most cases. However, there were some gaps in the midwives room checks but the resuscitaires, defibrillators and airway suction equipment had all been checked. We found four syringe pumps. Three had been tested recently and one was overdue a portable appliance test in November 2015.
- Equipment available in the antenatal clinics included baby changing and feeding facilities available. The blood and glucose monitor had been calibrated each day. However, the logs were kept independently of the equipment.
- Sonicaids (used for monitoring the fetal heart rate) were available in triage and the day care assessment unit

along with electronic blood pressure monitors. Staff told us that there was no shortage of equipment and that additional equipment could be requested and was provided in a timely manner.
- Staff raised concerns that there was a shortage of space on the women's health unit in the recovery and clinic areas. Additionally, there was a lack of beds for gynaecology patients when there were medical patients on the ward.
- Equipment was assessed as part of the ward accreditation framework. Indicators included were that staff were aware of how and where to obtain equipment in a timely manner and that equipment is stored appropriately.

Medicines

- Drugs were stored appropriately on each area we visited. Temperatures on the medicines fridge were checked and recorded daily. The keys were held by the shift leader. The preparation of medicines room was secured with swipe card access.
- Medications were checked regularly and stock levels were noted to be correct. Take home medication was in the locked cupboard.
- Emergency drugs for Postpartum Haemorrhage (PPH) were in a box and ready for use. There were also trolleys ready with drugs for emergency adult and neonatal resuscitation. These trolleys were securely tagged and dated.
- We read a report from the consultant pharmacist listing details of medication incidents across the trust in the second quarter of 2015/16. The report highlighted any trends and learning from medication incidents and actions for improvement in medication safety. We saw that incidents occurring in the Women and Children's directorate accounted for 8.8% of total medication incidents reported across the trust. Maternity and gynaecology were not listed amongst the ten clinical areas with the highest report rates.
- The consultant pharmacist did report on an incident in maternity involving a high risk injectable medication. The incident involved a postnatal woman receiving magnesium intravenously via an infusion and potentially had received a higher than intended dose inadvertently. An investigation was in progress but colleagues had been reminded to double check the infusion rate of magnesium in line with trust policy.

Records

- There were different systems in operation for patient records which included red books, paper hospital records and handheld notes. There was also an electronic patient record. The triage service used a paper based log but was about to move on to an electronic system.
- The staff we spoke with were pleased to be moving towards more electronic record keeping as they felt this would make retrieval of notes more efficient and would eliminate some duplication where information contained in paper notes was also held electronically. However, community midwives expressed frustration about seeing women in Sure Start Children Centres where there was no access to the NHS electronic systems. They told us that first bookings with women in these centres were captured on paper and then the community midwife would travel to the hospital to input the information onto the electronic record.
- We inspected eight sets of patient records. Of the eight, five had either the name of the midwife in charge of the woman's care or, for high risk cases, the name of the consultant. However, two of the records did not contain an individualised case plan for pregnancy and labour. VTE assessments were held electronically.
- All the records had observations recorded and a modified early obstetric warning system chart (MEWOS) was present with a score calculated. This is a system for the early detection of seriously ill women and for alerting the clinicians when a woman's health is deteriorating. All entries in the notes were correctly signed and dated.
- The ward accreditation framework included a section on assessing the standard of accurate recording keeping which was helping to maintain and improve standards of record keeping. The obstetric reports for September and December 2015 included a section on the incidents involving the unavailability of patient's records. This identified there were seven cases reported, in September. Six occurred on the delivery suite and one was from the antenatal clinics. In this report it was stated that the flow chart had been distributed to all clinical areas on how to access notes in antenatal clinics and during the night.
- In the December report, there were three incidents involving lost or absent medical records. Two occurred on the delivery suite and one in the antenatal clinic. It

was also noted in this report that there had been a couple of incidents of the patient information misfiled in a patient's notes. Staff had been reminded to take care not to mix-up loose papers from different files particularly in the antenatal clinics.

Safeguarding

- There was a named midwife for safeguarding and a specialist midwife for safeguarding children. There were policies for safeguarding adults, mental capacity, and deprivation of liberties, domestic abuse, learning disability and restraint.
- The service had a dedicated team of specialist midwives to support and advice midwives working with vulnerable women and, where risk factors were identified. The specialist team included a specialist midwife for mental health, bereavement and teenage pregnancy. The Head of Midwifery attended the adult safeguarding sub-committee meetings.
- When we attended the labour ward forum meeting in January 2016, the Mental Health Liaison Midwife presented a new version of the mental health guidelines, Care of Antenatal, Intrapartum and Postnatal Women with Mental Health Problems. These guidelines were comprehensive and covered mental health conditions in pregnancy from mild to severe and the procedures to adopt from the initial mental health risk assessment to the advice to give women on specific medication and breast feeding.
- Specialist antenatal clinics were available for women with mental health issues, teenage pregnancy, smoking cessation, women who are subject to domestic violence or alcohol/substance abuse and women with a raised body mass index (BMI).
- A report to the board in July 2015 described how failure to meet trust targets in relation to implementing safeguarding measures was lowering the outcomes in the ward accreditation process. The ward accreditation framework demonstrated that, between April 2014 and March 2015, more than 40% of wards had achieved less than Gold, Silver or a Bronze rating in relation to the safeguarding indicators.
- Safeguarding adults training data showed 92% overall staff compliance, with 95% completion for level one and 90% completion for level two. This was better than the trust target of 85%. There was a detailed action plan to continue audits in this area and to improve performance in relation to compliance with training.
- Level three training was targeted on critical specialities such as obstetrics and midwifery and average compliance across this speciality was 79.20%. The traffic light rating system categorised any score less than 79% as inadequate. Trust data indicated that in October 2015, 92% of community midwives and 35% of obstetric medical staff were compliant with safeguarding children, level three. At the time of the inspection, midwifery staff overall were 76.19% compliant and obstetric medical staff were 55% compliant with safeguarding children, level three training. The action plan indicated that there would be a continued push to increase staff attendance on the level three study day. However, it was evident from previous data that this had been a long standing concern within maternity services.
- Midwifery staff were knowledgeable about female genital mutilation (FGM) and the responsibilities of individuals to report cases involving under 18 year olds to the police and safeguarding. Cases in the area were rare. There was a clear process in place to ensure there was a record of concerns clearly documented within the patient's health record. However the guideline on FGM was out of date as it was due for review in November 2015.
- Midwives told us that the specialist safeguarding midwives were always available to offer guidance and support and midwives could 'drop in' for advice on a case at any time. Safeguarding supervision was available when required but there was not a timetable for regular supervision sessions. The specialist midwives told us that, following our discussions, they would introduce a more structured system for safeguarding supervision.
- The trust had developed a child sexual exploitation policy and staff had undertaken training within this area.

Mandatory training

- Staff received mandatory training on a rolling annual programme. Mandatory training included areas such as moving and handling, fire safety, conflict resolution and dementia awareness.
- Trust data showed that 84.8% of staff with the Women and Children's Directorate were compliant with mandatory training, which was slightly below the trust target of 85%. Within gynaecology services, mandatory training figures ranged between 60% (information governance) and 100%. Overall, staff were positive

about the availability of training. However, the community midwives told us they had difficulties in attending mandatory training due to capacity issues and they were completing training in their own time.

- The Head of Midwifery was aware of the lack of time for mandatory training and how difficult it was for community midwives to attend. She told us that a new practice based development midwife had started in post. The post holder told us study days were being made available to enable midwives to 'drop-in' for a block of training covering several modules. Additionally plans were in place to make greater use of on-line training to make training more accessible. Uptake of training on mechanical devices, blood transfusion and emergency skills had recently improved.

Assessing and responding to patient risk

- The external consultant we spoke with working on the risk and governance processes at the trust told us that she began work in January 2016 and had found the service in 'transition'. She found that the service had moved away from well-established processes and experienced personnel to a period of unplanned change, which had left some gaps in the framework for assessing and responding to patient risk.
- Staff expressed their concerns in terms of the senior medical rota on delivery suite. Staff felt that the management of patient risk was fragmented and there was little continuity of care due to the rota being split into four separate shifts. We were informed this could lead to care plans changing more frequently and clinicians delaying making a decision until the next doctor took over.
- An audit of ten observation charts undertaken in July 2015 demonstrated high levels of compliance with the Modified Early Warning Score, 'MEWS' system, on the gynaecology ward. In the ten cases audited, 96% contained a full set of observations, 100% had a score recorded with 91% accuracy, 78% of cases had been recorded as frequently as advised in the protocol and 91% fully complied with the policy.
- An audit was conducted in relation to the World Health Organisation (WHO) 'safer surgery' policy and how it was implemented on the delivery suite. Theatre staff observed teams performing operations during one session each week over several months and recorded adherence to all stages from the initial team brief to final sign out. Any verified failures to follow the policy were reported as a clinical incident. The results showed 100% adherence from April to September 2015 in more than 100 operations.
- Health records revealed that risk assessments were conducted for all women in gynaecology and maternity units. Risk assessments were used to determine if a pregnancy and labour were likely to be low or high risk and whether a home birth or midwife-led birth was appropriate in all the circumstances. Risks considered included maternity history, multiple birth, previous caesarean section, weight, age, blood pressure and conditions such as diabetes.
- At the morning handovers and multidisciplinary meeting we attended on the delivery suite, there was clear emphasis on risk and safety and ensuring there was enough staff to deal with the number or women and the complexity of their needs.

Midwifery staffing

- The ratio of midwives to births within the service at the time of our visit was one midwife to every 31 births, which was worse than the England average and trust target of one midwife to 28 births. It was evident, from the maternity dashboard, that the service had not been compliant with this target since February 2015. However, senior staff and midwifes said there was one to one care in labour in the birth centre and on the delivery suite.
- The Head of Midwifery informed us that the current ratio reflected the increase in the number of retirements from the service and the current vacancies. The service had anticipated the retirements conducting an age profiling exercise at the beginning of 2015. The service had employed 13 newly qualified midwives who started in post in October and November 2015 and was recruiting more senior midwives, at the time of the inspection, to improve the skill mix. Three senior midwives had recently been promoted into the role of matron in maternity and gynaecology.
- The total agreed establishment of qualified midwives for the service was 157 with approximately four vacancies. There was also an establishment of 58 midwife support workers with one vacancy
- In November 2015 a 'Birthrate Plus' review of the unit's ratios was undertaken. Birthrate Plus is a workforce planning system based on the principle of one to one care during labour and reflects the capacity, acuity and demand for services. It was evident from this work that

the service had an overall deficit of approximately 4.5 posts in relation to the current establishment. These results were due to be reviewed within the service with a view of returning the service to the ratio of one midwife to every 28 births.

- The service had a number of specialist roles including midwives for safeguarding, bereavement, mental health, teenage pregnancy, infant feeding, audit, risk and antenatal screening. Additionally there was the post of practice based development midwife to support the newly qualified midwives and a development programme for the newly appointed matrons.
- In response to suggestions from staff, a number of clerical and administration appointments to support midwives were due to be appointed to enable seven day ward clerk cover and a 24 hour reception.
- The maternity service did not use agency staff but instead used their own staff to do additional shifts through a staffing bank. They were also able to use mobile communication, text and a closed Facebook Group, to alert the on-call midwives and to contact staff quickly to offer extra shifts. They also had a supervisor of midwives on call.
- We inspected the planned staffing levels on the antenatal, postnatal and gynaecology wards compared to the actual levels of staffing from July 2015 through to October 2015. The areas that were occasionally understaffed were the antenatal and postnatal wards. The gynaecology ward was always staffed according to the planned staffing levels.
- Within gynaecology, the planned and actual staffing levels for physiotherapy and occupational therapy were the same in July and August 2015. However in September and October 2015 only 50% of shifts were the same.

Medical staffing

- Within maternity services there were 13 consultant posts, including two employed on part-time contracts and two locums. There was a mixture of resident and non-resident consultants and two were new consultants who had joined the team following the substantive appointment of the Clinical Director in December 2015.
- There was discrepancy in weekly consultant cover data. We were informed that there were an average of 141 weekly hours of consultant cover on the labour ward between January 2014 and May 2015. However, the maternity dashboard had a target of 98 hours a week and had recorded 147 hours a week, or more, from July to December 2015. When we discussed this with the Clinical Director he told us 120 hours a week would be a more accurate figure.
- In addition to consultant cover, there were two further tiers of medical cover. The first tier was a middle grade rota of six doctors, which included two doctors on site during the day for obstetrics and one for gynaecology. There was a second tier of 12 registrars, including six trust doctors and six trainees. On-call rotas were covered by resident and non-resident consultants and there was tier one and two night cover for obstetrics and gynaecology. There was a dedicated team to perform the elective caesarean sections. Each consultant clinic would also have a tier one doctor and a registrar.
- There was dedicated anaesthetic cover during weekdays by one consultant and a trainee, which allowed elective and emergency work to be managed effectively and concurrently. The night was covered by a pool of trainees who were deemed competent to be on the obstetrics rota following observation by the consultants. First on call consultant anaesthetists provided emergency support, all of whom had done some obstetrics anaesthesia. There were plans to increase the number of consultant anaesthetists with obstetric sessions.
- Midwives told us they sometimes found it difficult to access doctors to see women in triage and the day assessment unit. They said there were insufficient consultant led clinics for women with more complex needs requiring close monitoring. We also heard, from senior midwives, that it was sometimes difficult for women to receive a senior clinical review in a timely way on the antenatal ward.

Major incident awareness and training

- The trust had a major incident plan and emergency preparedness strategy and work plan, which included a 'readiness status' for a range of possible emergency scenarios, such as a telecommunications failure, sever weather or a fuel crisis. Staff were aware of these plans and told us regular trust wide drills involving cascading lists of important phone contacts, discharging patients ready to go home and shifting on to an emergency only service.
- Staff were also trained to manage patients presenting with infectious diseases such as Ebola. A serious disease originating in Africa and the Middle East.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

We rated the service as 'good' for being effective.

Staff working in maternity and gynaecology services offered evidence based care and treatment based on national guidance and standards. However, some of the local guidance was out of date.

Midwives had been trained to perform effectively in their roles and mothers said that they were both competent and professional.

The service was continually monitoring patient outcomes through the use of a rolling dashboard and audits. In response to a CQC 'outlier alert' there had been an in-depth audit of neonatal readmissions and, as a result, appropriate changes were implemented to improve outcomes. The auditing process has continued.

Multi-disciplinary working was good both within the service and with agency partners. Pain management was available and the service was supporting the development of new approaches.

However, many of the trust's maternity service guidelines were out of date. We looked at 53 guidelines and found 28 of them were out of date.

Gynaecology services did not have a service dashboard. The rate of gynaecology readmissions was worse than the trust target, with a readmission rate of 6.9%.

There was an imbalance in skill mix and experience within the midwifery service in that several senior midwifes had recently retired and 14 newly qualified midwifes had been recruited. In addition, a number of midwives have been newly promoted to matron and they were also developing in their new roles.

Between April and October 2015, 75% of staff had received their appraisal which was lower than the trust target of 85%. The rates for completion in the same period in 2014 had been 100%. This rate was 62.50% on ward F16 for nursing staff and 100% for clerical staff. Midwifery specific training update was low in areas including breastfeeding (31% compliance) and epidural training (33% compliance).

Evidence-based care and treatment

- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) such as CG190 guidance for intrapartum care for health women and babies.
- The service was processing a number of the trust's quality standards to ensure they were in line with NICE guidance and the National Confidential Enquiry into Patient Outcome and Death (NCEPDO) compliance policy. These included local guidance on hypertension, postnatal care, multi pregnancies, induction and ectopic pregnancy. Staff were alerted to any new or updated guidance through the labour ward forum.
- The trust was taking part in the maternal, newborn and infant clinical outcome review programme. A presentation had been delivered to staff, at the labour ward forum, of the perinatal mortality report from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) across the UK for births in 2013.
- Reference was made to NICE guideline CG 192 (2014), Antenatal and postnatal mental health: clinical management and service guidance, in the new version of the service guidance on Mental Health- Care of Antenatal, Intrapartum and Postnatal Women with Mental Health Problems. Other documents referenced were the National Society for the Protection of Cruelty to Children (2013), Prevention in Mind: Spotlight report on perinatal mental health and the Scottish Intercollegiate Guidelines Network guidance on the management of perinatal mood disorders (2012).
- However, many of the trust's maternity service guidelines were out of date. We looked at 53 guidelines and found 28 of them were out of date. Examples of out of date guidelines included: Guideline for Care of the Rhesus Negative Pregnant Patient, which was due for review in 2011. A further example was the Guideline for the Management of Pregnant and Recently Delivered Women who attend the Emergency Department or Require Admission to a General Ward, which was due for review in October 2013.
- The Head of Midwifery acknowledged that many of the services guidelines were out of date and that the guideline group had not been meeting to review and update guidelines for several months. She reported that

the group was about to start meeting shortly and would deal with the backlog of out of date guidelines. In the meantime, staff had access to up to date guidance via the national clinical websites.

- We visited the nurse colposcopist who said that there had been a formal quality assurance visit in 2011 and an informal visit in 2015 and there was an action plan that was being monitored by the quality assurance team. However, the Clinical Director said, although there were unit protocols and guidance agreed, 'adherence is not universal with wide variation in the practice of clinicians. For example, the practice of six monthly follow up persists which contravenes best practice guidance for the management of low grade smear abnormality'. We saw trust out-patient colposcopy and hysteroscopy leaflets on the website that were both in date.

Pain relief

- On the trust maternity web page there was a comprehensive list of pain relief options during labour, including use of the birthing pool, 'gas and air' (a mixture of diamorphine/pethidine and Entonox to breath in through a mask) and trascutaneouls electrical nerve stimulation (TENS) machine.
- Patients we spoke with on both the maternity and gynaecology unit told us they were happy with the pain relief they were given and the options open to them.
- An anaesthetist was readily available on delivery suite to support women who required an epidural during labour.
- There was enhanced recovery pathway documentation for vaginal hysterectomy and total abdominal hysterectomy. Both contained a pre-operative assessment and details of the meeting with the anaesthetist, the name of the anaesthetist and the type of anaesthetic to be used. It included a pain score before and after surgery and at discharge.
- In the records we inspected we saw that pain scores were assessed using a recognised pain score tool.

Nutrition and hydration

- The service was using the Malnutrition Universal Screen Tool (MUST) and we found there were nutritional care plans for women, particularly those who had undergone surgery. A red tray system w and food charts were used for those women who were at risk of malnutrition.
- An audit (undated) of the NICE quality standard 98 for Nutrition: Improving Maternal and Child Nutrition had been undertaken which demonstrated the service was compliant with promoting healthy eating in pregnancy in that information was given at the first booking appointment. However, data was not collected on the number of women receiving the advice.
- The service had a specialist infant feeding coordinator and additional breastfeeding support was available in the community to reduce the neonatal readmissions and the process of early discharge and enhanced recovery. The service had achieved level three of the UNICEF's baby friendly initiative. Approximately 75% of women, at the trust, were breastfeeding immediately post-delivery.
- Women with spoke with had mixed views about the food they were offered particularly in terms of the choice available to them and how healthy the food was.

Patient outcomes

- Information about the outcomes of patient's care and treatment were collected and monitored by the service through the governance and risk management processes, the maternity dashboard and the monthly performance board. However, we asked to see the gynaecology dashboard but we were informed that the service did not keep one.
- There were 4412 births in 2015 compared to 4217 in 2014, which was a 4.62% increase. Of these, 38 were home births in 2015, an increase of 11.76% on 2014. Despite the increase in births, the number of epidurals for labour fell from 567 in 2014 to 507 in 2015, a decrease of 10.58%. The total of normal, unassisted, births rose from 2290 in 2014 to 2464 in 2015.
- The trust had seen a decline in the numbers of stillbirth from 2013 to 2015. There were 21 still births in 2013, 15 in 2014 and 14 in 2015. We saw the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) report for perinatal mortality for birth in 2013 (published June 2015). During 2013, the trust had a stillbirth rate up to 10% higher than the average for similar trusts. When were visited, the trust had just received this report and had not yet responded.
- The directorate performance report for November 2015 to the board for women's and children's services, which showed all specialities were within the target rate of 5% for readmissions within 30 days, except gynaecology where there was a rate of 6.9%. In addition, the gynaecology service was not meeting the target for 18 weeks from referral to treatment waiting times.

- The intelligent monitoring data for 2014 showed that the trust performance was similar to the main body of NHS trusts in relation to the method of delivery. The proportion of normal (unassisted) births was slightly lower than the England average, with a slightly higher proportion of elective caesareans sections.
- The maternity dashboard for 2015 showed the variation for elective caesarean sections ranged between 24.10% (May 2015) 34.70% (October 2015). The trust had set a goal of 23% for this rate with a 'red flag' for any rate above 24%. However, the service had been above this rate since in all but five months in the last six years.
- An audit of category one emergency caesarean sections had been undertaken to look at the time between the decisions to deliver by caesarean and the delivery itself. Category one is defined as where there is immediate threat to the life of the woman or fetus. The target was 30 minutes and the audit demonstrated that the service achieved that target in 93% of the 30 cases captured by the audit in June to August 2015.
- In November 2014, the Care Quality Commission (CQC) had noted and informed the trust that newborn babies discharged home were statistically more likely to be readmitted to the trust than newborn babies in other trusts in England. The CQC issued an 'outlier alert' to the trust and asked the trust to respond with information to help answer specific questions about the alert. At the time of the inspection CQC was continuing to monitor this. The service had conducted two further audits of neonatal readmission, in May 2015 and August 2015. The audit for August 2015 noted that, in the three month period, 27 babies were readmitted to the hospital. The trust had conducted a detailed analysis of the reasons for readmission which were most commonly weight loss and neonatal jaundice. An action plan had been written following this audit and learning was being used to support midwives within the service and further audits were planned.
- A further area on the maternity dashboard that was consistently exceeding the service's own target was for third and fourth degree tears. The service had set a target of no more than six a month, which had been exceeded seven times in 2015.

Competent staff

- There was an imbalance in skill mix and experience within the midwifery service in that several senior midwifes had recently retired and 14 newly qualified midwifes had been recruited. In addition, a number of midwives have been newly promoted to matron and they were also developing in their new roles.
- The service was supporting staff with a new practice based development role and training was available for the newly appointed matrons in areas such as coaching, leadership behaviours and developing resilience.
- The trust had 20 supervisors of midwives who provided supervision for 217 midwives, giving a ratio as 1:10. However there were some supervisory caseloads higher than requirement of 1:15 with the highest caseload being 1:38. The team were supporting newly qualified supervisors to hold a reduced caseload which meant that the more experienced supervisors had a higher caseload.
- Between April and October 2015, 75% of staff had received their appraisal which was lower than the trust target of 85%. The rates for completion in the same period in 2014 had been 100%. This rate was 62.50% on ward F16 for nursing staff and 100% for clerical staff.
- Staff we spoke with in maternity and gynaecology said that they were satisfied with the levels of support they received for development. Midwives who had recently completed the 12 to 18 month preceptorship programme said that they had been well supported throughout. In the maternity education strategy, the training available to staff included neonatal examination of the newborn, newborn feeding, maternity anaesthetic competencies and skills drills for resuscitation, haemorrhage, shoulder dystocia, cord prolapse and eclampsia.
- The Clinical Director raised concerns that the service had lost some of its good reputation regionally for teaching and training. He informed us that trainees had fed back to the deanery that there had been a lack of clinical support and teaching. The trust informed us that these concerns related to a lack of clinical support and teaching in 2012. However the junior doctors that we spoke with during the inspection did not share this view and felt they received good training opportunities. One of the consultants we spoke with said the new rotas would make it easier to engage with learning and development activities.
- Monthly feedback on training compliance was discussed at the labour ward forum. At the December 2015 meeting it was reported that epidural training for midwives was at 33% compliance and one of the

practice based development midwives advised that it should be mandatory for all midwives working on the delivery suite. Compliance with training for breastfeeding was at 31%. At the meeting in January 2016 the training figures were described as poor.

- We reviewed the newly completed version of the maternity education strategy and this included a training needs analysis for maternity. It was noted in the report that all staff received risk management training as part of their general induction and there was additional management training as part of the local induction to the service. Risk management training is also provided on the local induction for obstetric medical staff.
- Midwives were also due to receive Cardiotocography (CTG) training and skills drills annually and epidural and adult and neonatal resuscitation training every two years. Other maternity specific training was taking place at induction such as maternity anaesthetics competences, bereavement and mental health training.
- Management training was available in coaching skills, effective appraisals and complaints investigation. At the labour ward forum meeting we attended, staff were arranging for midwifery training in conducting root cause analysis following serious incidents.

Multidisciplinary working

- We observed a multi-disciplinary handover meeting on the delivery suite. It was a well-attended meeting with two consultant anaesthetists, obstetrics and gynaecology consultants, staff from the neonatal unit, the birth centre, post and antenatal wards. The delivery suite lead and the midwife in charge of the delivery suite were chairing the meeting and inviting contributions from all those present.
- At the MDT meeting, there were constructive discussions about each of the women listed on the board and the plan for their care. There was also an assessment of staffing levels and who would be attending to what. Staff went through the number of caesarean sections planned and the individual women on the antenatal ward awaiting induction of labour. They also discussed capacity on the postnatal ward and patients, including non-gynaecology patients, on ward F16.
- We saw how the team worked together to stagger the inductions and arrange suitable timings for the elective caesarean sections. One of the midwives alerted the team to a safeguarding issue. We were informed that there would be further handovers at 13:00 and at 17:00.
- We also spoke with community midwives who attended meetings with each other professionals, including hospital based midwifes and specialist midwives, colleagues from social services, health visitors and consultants and GPs. At the midwives focus group the student midwives said they were impressed with the multi-disciplinary team meetings and how they felt valued within the team.

Seven-day services

- The delivery suite, midwife-led birthing unit, triage and the wards were open 24 hours a day seven days a week. Consultants and anaesthetists were available out of hours either in the hospital or on-call.
- The Day Assessment Unit was open Monday to Saturday, fetal monitoring and ultra sound scanning was available.
- The early pregnancy and gynaecology emergency unit was not open at weekends and so women urgently requiring these services were required to attend the emergency department and were triaged to F16.
- There were on-call community midwives at the evening and weekends.

Access to information

- Staff could access information through the trust intranet where all the clinical guidelines were listed. Community midwives were looking forward to receiving tablet computers to enable to access and input information remotely.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with the antenatal and newborn screening midwife and she told us about the importance of obtaining informed consent in screening. She said that they sent out a leaflet, 'screening tests for you and your baby' and, at the first appointment they asked the mother is she had read the booklet and what she understood from it. She said that the midwife would assess whether the woman had understood.
- There was new guidance entitled: Mental Health - Care Of Antenatal, Intrapartum and Postnatal Women with

Mental Health Problems. The guidance had a section on women in the service who lacked capacity. When were spoke with midwives about this they told us that they would seek advice where required.

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity.

Are maternity and gynaecology services caring?

Good

We rated the service as 'good' for caring.

We received feedback through the friends and family survey that women and their families had a good experience in the maternity and gynaecology services. We also witnessed behaviours from staff that indicated that they were using a caring and compassionate approach. Staff also took care to protect the dignity and privacy of women in all areas of the service and there was good support for women and their partners experiencing pregnancy loss.

Partners were made to feel welcome and involved in the pregnancy, labour and birth.

Compassionate care

- Patients were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
- We saw midwives and nurses on all the wards we visited knocking on doors before entering the room or just opening the curtains wide enough to pass through. Staff introduced themselves and we could hear sensitive and respectful conversations.
- We heard a midwife on the telephone to a woman in triage using a calm reassuring voice and listening carefully to what the woman was saying. Her manner was sympathetic and caring.
- The NHS friends & family test (FFT) (a survey which asks patients whether they would recommend the NHS service they have received to friends and family) results showed that the percentage of patients who would recommend the antenatal services was 95% which was the same as the England average. The percentage of patients who would recommend the maternity ward was 78% (December 2015) which was much worse than the England average of 93%. The percentage of patients who would recommend the birth services was 100% (December 2015) which was better than the national average of 97%. However the response rate was low at 13.7%.
- The percentage of patients who would recommend the postnatal community provision services was higher than the England average of 97%. The trust's performance for August 2015 and September 2015 for those who would recommend the service was 100%.

Understanding and involvement of patients and those close to them

- Staff involved patients in their care. We saw consultants and nursing staff keeping family members up to date with information about patients where appropriate. Patients' families reported good communication about care. Patients and relatives we spoke with knew about their family members' diagnosis, treatment and investigations.
- All the women we spoke with said that the doctors explained everything clearly and answered their questions. Patients and relatives spoke favourably about the information they received from staff both verbally and written, such as information leaflets which were specific to their condition.

Emotional support

- The trust had a bereavement midwife who told us she was supported by the Matrons and the Head of Midwifery to create a dedicated bereavement centre. The bereavement midwife's remit was to offer support women who had suffered fetal loss after 16 weeks of pregnancy and parents from the neonatal unit. Women could self- refer, be recommended by the community midwives or the switchboard would refer a distressed women on the telephone. The bereavement midwife had four years' experience of person-centred counselling. She also received de-briefing support off-site from an independent counsellor and support on-site from a supervisor of midwives and from the chaplaincy.

Maternity and gynaecology

- There was a bereavement room which was a self-contained unit located off the antenatal ward. The unit had a private entrance and exit that led to the free 'compassionate' car parking space. There was a kitchen area with fridge and microwave, a hospital bed and fold down bed for partners and a counselling room.
- There was a 'rainbow clinic' which was for women who had become pregnant following a previous stillbirth. This clinic offered a 'one stop' service for next pregnancies with support from a sonographer, consultant, two registrars and the bereavement midwife.
- The trust followed a Still Birth Integrated Care Pathway along with Greater Manchester, Lancashire and South Cumbria. The pathway followed the mother and her partner through all stages from care around diagnosis through to delivery, post mortem and funeral arrangements. There was also a section on any plan for future pregnancy.

Are maternity and gynaecology services responsive?

Good

We rated the service as 'good' for responsive.

The service was responsive to the individual needs of women and their families from different communities. Specialist support was available for young pregnant women, those with alcohol and drug addictions and women with mental health issues. Improvement plans were linked directly to feedback from women.

Careful service planning was improving responsiveness through more specialist clinics and specialist pathways.

People could raise concerns and complaints and be confident this would be investigated and responded to appropriately. There was evidence the trust used complaints to improve the services.

However, the delivery suite was closed twice in December 2015. On the first occasion the unit was closed for five and a half hours because of the pressure on clinicians and staff sickness and the second closure was for 30 hours. This was because the unit had become overly busy and 17 women were diverted by the triage service to other maternity services available locally.

The smooth flow of patients on ward F16 was interrupted by limited access to sonography. The shortage of scanning sessions available in the early pregnancy assessment unit led to unnecessary admissions to the ward.

Gynaecology service was not meeting the target for 18 weeks from referral to treatment waiting times.

Service planning and delivery to meet the needs of local people

- The service had specialist midwives, including mental health and bereavement, to meet the needs of local women. There was also a midwifery lead for newborn health and infant feeding, and a mental health clinic with a lead obstetrician and psychiatrist. There was a specialist team providing midwifery services at the local women's prison
- There were also clinics for haematology, diabetes and a perineal trauma clinic led by an advanced midwife practitioner. As the trust was a regional adult cystic fibrosis specialist tertiary centre, there was tailored maternity care for a cohort of female cystic fibrosis patients.
- The infant feeding strategy had been modified in January 2016 in response to the audit of neonatal re-admissions. These modifications were directly related to the needs of mothers and babies and included ensuring that all babies placed on a weight loss management plan had a set of baseline clinical observations including temperature, heart rate, and alertness. The service adjusted length and frequency of visits to new mothers and babies who required increased support, such as babies with feeding difficulties.
- The unit had introduced increased breast feeding support in the community delivered by maternity support workers to reduce the neonatal readmissions and the process of early discharge.
- The service had introduced an enhanced recovery pathway for elective caesarean section with low risk cases to improve the patient experience. The service had also supported the training of a midwife in ultrasonography in order to support the outpatient inductions, day care and triage areas.
- There was a Rainbow Clinic to support women with stillbirth and pregnancy loss and to support research aimed at reducing stillbirth.

Access and flow

Maternity and gynaecology

- The delivery suite was closed twice in December 2015. The first occasion was on 14 December when the unit was closed for five and a half hours because of the pressure on clinicians and staff sickness. The second closure was on 18 December and was for 30 hours. This was because the unit had become overly busy and 17 women were diverted by the triage service to other maternity services available locally.
- Other closures of the service in 2015 included 15 hours in July, seven and a half hours in August, 12 hours in September and 52.5 hours in October. The reasons for the closures were predominantly a combination of staffing levels and demand on the service. Senior leaders told us there were clear escalation procedures in place to enable the service to respond safely. Following the December closures, midwives on the triage service had been provided with better local maps to help redirect women to their nearest service.
- Maternity service records indicated that between 15 -16% of all babies delivered in the service were delivered in the birth centre. In addition, of the mothers that planned to have their babies in the birth centre between 30 – 40% transferred to delivery suite because of a delay or complications with the labour or because the woman requested to have an epidural.
- The number of new bookings for women in early pregnancy was recorded to enable the service to predict the number of births. The service was anticipating a small rise in the number of births at the hospital in 2016.
- Staff discussed access and flow at the handover meetings. Elective caesarean sections were conducted by a separate team which ensured elective work was not delayed by emergency cases unless the service became very busy. The staff were active in delaying or staggering the induction of labour to match capacity within the service.
- In gynaecology, nurses said that access and flow was affected by the number of non-gynaecology patients on the ward. Nurses told us sometimes they found that their work preparing women for gynaecology surgery was delayed because they had to attend to an older patient with limited mobility or living with dementia.
- Staff also informed us that the smooth flow of patients on ward F16 was interrupted by limited access to sonography. The shortage of scanning sessions available in the early pregnancy assessment unit led to unnecessary admissions to the ward.
- Staff raised concerns about the lack of space on ward F16 and informed us that patients in the day case unit may not have a bed before and after surgery but were accommodated on trolleys and recliners.
- All the midwives we spoke with said that they welcomed the change in the consultant rota on the delivery suite. Senior leaders told us this meant that decisions were not delayed or postponed. Additionally there were less frequent changes in a woman's plan of care due to frequent changes in the medical team, which could lead to confusion and upset for the women and their families.
- Midwives told us they sometimes found it difficult to access doctors to see women in triage and the day assessment unit. They said there were insufficient consultant led clinics for women with more complex needs requiring close monitoring. We also heard, from senior midwives, that it was sometimes difficult for women to receive a senior clinical review in a timely way on the antenatal ward.
- Women requiring a scan in an emergency were expected to attend the emergency department or be admitted as an in-patient on ward F16. This was due to a shortage in the number of sonographers and the limitation this placed on the number of ultrasound scanning slots available for women in the early pregnancy unit and in gynaecology outpatient clinics.

Meeting people's individual needs

- If women were assessed as low risk, they had the option of choosing a home birth or delivering in the Birth Centre. However, women assessed as likely to have a higher risk birth, with medical or obstetric complications, were advised to have a consultant lead hospital birth. Antenatal clinics for initial booking appointments were held in children's centres midwives did not need to travel. Vulnerable women were referred to the specialist midwives who provided greater expertise and had more time to spend with individual women.
- The service also supported women with a range of supplementary therapies available in a dedicated therapy room. These included massage therapy and hypnobirthing. Whilst these therapies were not available on the NHS the NHS midwives would support women who chose to use them.
- Information was freely available for women on the trust website and the trust's maternity website. There were

useful videos entitled Maternity TV and hospital tours could be arranged. There was also written information about choices and facilities and a range of useful, up-to-date leaflets on all areas of pregnancy and birth.

- There was an interpreter service and a language line for women whose first language was not English. Leaflets, translated into the languages spoken by the minority groups living locally, were available on the website.
- The service had developed a number of guidance and policies to meet the needs of more vulnerable women such as guidelines for teenage pregnancy, alcohol assessment and a domestic violence and abuse policy. The domestic violence and abuse policy included guidance on forced marriage, honour based violence and female genital mutilation. The policy also listed the agencies it was working with on these issues such as the Manchester Adult Social Care and the Multi Agency Risk Assessment Conference which involved the police and local agencies involved in housing, schools, women's aid and safeguarding services.

Learning from complaints and concerns

- The trust had a complaints policy and we saw that details about how to make a complaint or how to contact the patient experience service were displayed on notice boards. Complaints leaflets were available in clinics and on ward areas. From November 2014 to October 2015 there were 50 complaints received for the maternity and gynaecology services. On average across the trust, it took 33 days to process complaints. Maternity was the fourth most common service complained about and most complaints across the trust were about clinical treatment, delays or cancelled appointments, the attitude of staff and communication.
- The Head of Midwifery dealt with all the complaints in maternity and ensured there was a thorough investigation and appropriate response.
- We reviewed the last six complaints about maternity and gynaecology services. One of the complaints we saw related to loss in pregnancy and the way this was managed by the service at such a distressing time for the woman and her partner. This complaint and several others involved recurring themes such as conflicting advice and guidance from different clinicians, delays in clinics and a standard of care that was affected by overly busy units. Complaints also raised difficulties arising from the lack of scanning facilities on ward F16 and the need to separate the services offered to those receiving antenatal care and those who had experienced a loss in pregnancy.
- An example we saw was a reminder to midwives to give women the leaflet about induction and tell them it is often more than one day before labour begins. There had been a complaint from a women who had uninformed expectations about the speed of labour following the initiation of induction. The hotspots were included in the safety huddle and daily handover on all units and wards for a full week. We noticed at the information was also written on the white board on the delivery suite.

Are maternity and gynaecology services well-led?

Requires improvement

We rated the service as 'requires improvement' for well-led.

There was a lack of engagement and leadership from senior clinicians within the service. This lack of engagement had resulted in a significant delay in investigating incidents and reviewing and updating clinical guidance.

Staff raised concerns in relation to having no involvement in risk management meetings or in the governance process other than reporting incidents. Staff also told us they did not receive feedback after reporting an incident.

A review of the services and of medical staffing in June 2015, in June 2015 concluded 'ineffective clinical leadership had resulted in a fragmented disorganised service with wide variation in practice, with no cohesion between the senior clinicians and no significant professional development or succession planning'.

The unit governance information and incident update had not been distributed since June 2015 and there was no group for reviewing and updating clinical guidelines. We subsequently saw no evidence of lessons learned being shared with staff.

Midwives and nurses were positive about working in the trust and being part of a team who understood and shared

the trust's vision. Staff were proud of the services they were able to deliver to women and their families. The Head of Midwifery was providing clear leadership and engaging her team.

Staff and service users were involved in shaping the future developments and improvements in the service.

Vision and strategy for this service

- We spoke with a range of staff, all of whom were aware of the trust's vision and strategy. When we asked staff in maternity services about the strategy for maternity, they were clear they wanted to provide the best possible care for women and their babies.
- We asked for the maternity and gynaecology strategy documents but only received a strategy for maternity.
- The midwives, particularly the community midwives, were proud of their team work. However, some of the hospital midwives expressed frustration at the lack of support from the senior doctors.
- Most of the staff we spoke with were positive about the appointment of the Clinical Director and were optimistic about the changes he was proposing. Midwives were very supportive of the new consultant rotas, however not all consultants were supportive of it.

Governance, risk management and quality measurement

- There had been a lack of obstetric risk lead, with the post being vacant since May 2015. This had been identified as a risk on the departmental risk register. The gap had also been identified by a service assessment undertaken in June 2015, where it was acknowledged there was a lack of senior clinical support. He also identified there was a significant problem with consultants not providing the lead midwife with reports in a timely fashion, when required, as part of investigations particularly root cause analysis reports.
- We discussed the concerns in terms of investigating incidents in a timely manner with the Risk and Governance Midwife, the Head of Midwifery, the Clinical Director, matrons and several clinicians. All informed us that the backlog in completing investigation reports had occurred because there had been little clinical input into the investigation of incidents and reports. We were told that a clinician who would lead on governance and risk management had been appointed and was due to start in post.
- Staff raised concerns in relation to having no involvement in risk management meetings or in the governance process other than reporting incidents. Staff also told us they did not receive feedback after reporting an incident.
- A risk identified on the risk register, reviewed on 23 October 2015, highlighted the failure to manage incidents in a timely manner. This identified that 50% of incident investigations and reports were incomplete from January to September 2015 which 'may lead to incidents not being adequately investigated'. The cause was described as staffing issues and inconsistent incident management. There was a target to address the backlog by the end of November 2015. A governance and risk midwife had recently been appointed. This midwife was working at reducing the amount of outstanding root cause analysis investigations and, at the time of the inspection, there were just four outstanding. The midwifery team had continued with the risk and governance processes without the required input from the clinical staff. However, the unit governance information and incident update had not been distributed since June 2015. In addition, there was no group for reviewing and updating clinical guidelines. Therefore we saw no evidence of lessons learned being shared with staff.
- There were two safety bulletins distributed across the trust called 'Safety First at UHSM' and 'Patient Safety One Liners'. Both these bulletins had safety information and reminders such as, information about the Duty Candour and about the tools employed to manage the dietary and hydration needs of patients.

Leadership of service

- Staff felt that the midwifery leadership was supportive and leaders were visible and approachable.
- A review of the services and of medical staffing in June 2015 concluded 'ineffective clinical leadership had resulted in a fragmented disorganised service with wide variation in practice, with no cohesion between the senior clinicians and no significant professional development or succession planning'. He presented his findings to the trust board and the quality improvement committee and began to implement a series of recommendations.
- Senior midwives, told us that relationships between midwifery, nursing and medical staff were good on an individual basis, but they were not providing the

leadership and support required within the service. Doctors we spoke with talked about 'tensions' within the service around: challenge to traditional practices from more modern approaches, consultants unwilling to accept leadership roles within the service and the arrival of new personnel without the engagement of the consultant body.

- The Clinical Director informed of us of tensions with the consultant body that some consultants had disengaged and, as a group, they were not offering an appropriate level of clinical leadership. The Clinical Director's recommendations involved changes to working practices, including the removal of the short shift rota for consultant cover on the delivery suite. The Clinical Director also recommended that the consultants work as a team in gynaecology, sharing the work more equitably and removing the unhelpful 'silos'. This was because he had found that just three consultants covered most of the surgery in gynaecology. He also wanted to change the frequency and timing of senior clinical reviews on the wards, a reconfiguration and modernisation of services in gynaecology and adherence to guidelines and protocols in colposcopy.
- Senior midwives felt the lack of clinical leadership had prevented service improvements.

Culture within the service

- At the time of our visit, consultants had been appointed to new leadership roles in the structure and changes were being implemented. There had been a consultant workshop to discuss the changes and there had been a trial of a new rota, with long shifts and opportunities for greater continuity of care, on the delivery suite. However, whilst the Clinical Director was fully committed to making the necessary changes, some medical staff we spoke with expressed a reluctance to engage and others said they were aware of 'continuing tensions' in the medical staffing body that were not in the best interests of the women and babies in the service.
- We found that the midwifery team had been continuing to work as effectively as they could without the contribution of the senior clinicians.

Public engagement

- We were informed that there was no longer a maternity services liaison committee for the trust. However, there was public engagement via the dedicated maternity website, the hospital patient opinion website, social media and the patient surveys including the NHS Friends and Family test and the national maternity survey.
- Maternity services at the trust were similar to the England average in the CQC survey of women's experiences of maternity services in 2015. The responses from women who gave birth at the trust in February 2015 were similar to other trusts for labour and birth, staff response times and communication and care in hospital after the birth. There were two areas where the trust performed better than other trusts in England and they were for women not being left alone by midwives or doctors at a time when it worried them and for raising a concern and having it taken seriously.

Staff engagement

- All the midwives spoken with felt engaged with the service and the trust.
- The Head of Midwifery provided us with details of the engagement strategy she had delivered throughout 2014 and 2015. She held a series of 12 informal group meetings in 2014 and 14 different meetings in 2015 with groups of staff at different levels and locations. She had also held four informal drop-in sessions and had invited staff to offer suggestions for improving services.
- Staff suggestions were fed back in a monthly newsletter where the action taken in response to feedback was listed. The Head of Midwifery had introduced the themes of staffing for a 'big conversation' in November 2015 and revalidation/CQC preparedness in December 2015.
- The Head of Midwifery also gathered suggested improvements from midwives which she presented at the consultant away day organised by the Clinical Director.
- Since the Clinical Director had joined the team he had organised work-shops and an away day to engage with the clinical leaders.

Innovation, improvement and sustainability

- We saw that the ward accreditation framework had been positive in encouraging a culture of continuous improvement in the maternity and gynaecology services. The Head of Midwifery reported the achievements in her newsletter and staff we spoke with said they felt they found the framework motivational.

Maternity and gynaecology

- The bereavement midwife had been nominated for the national Butterfly awards two years running. These are awards celebrating survivors and champions of baby loss. The bereavement midwife was also runner up in the Royal College of Midwifery awards for her work providing bereavement support.
- A rapid access clinic had been introduced for menstrual disorders and post-menopausal bleeding to meet demand and allow for the development of innovative out-patient treatments such as microwave endometrial ablation (Endometrial ablation is a surgical treatment for women who have heavy periods) and hysteroscopy sterilisation (permanent, less-invasive surgical sterilization procedure for women).

Services for children and young people

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

Information about the service

The children and young people service at University Hospital of South Manchester NHS Foundation Trust delivers care at Wythenshawe Hospital to children between 0-18 years old. Between July 2014 and June 2015 5,981 children aged between 0 - 17 year olds were seen by the children's service.

The Starlight ward comprised of a 24 bedded inpatient unit (including a high dependency unit), a 10 bedded paediatric observation and assessment unit, an eight bedded day case unit and an outpatients department caring for children aged 0-17 years of age in a child and family friendly environment. The day case unit was based on Starlight ward and treated patients who attended for minor procedures. It was staffed by a separate nursing team.

The service offered a wide range of clinical provision; this included paediatric medicine and services in epilepsy, diabetes, cystic fibrosis, allergy, neonatal and cardiac service. There was a high dependency unit (HDU) and the surgical team performed surgery in an array of specialities such as ear, nose and throat (ENT), orthopaedics, general surgery, plastic surgery and maxillofacial. The service also had access to child psychiatry services from a neighbouring trust. The starlight ward provided for in-patients and their siblings with a playroom, sensory room and a teen zone all of which met the needs of children visiting the service.

We inspected Wythenshawe Hospital between the 26 and 29 January 2016 and an unannounced inspection took place on the 4 February 2016. As part of the inspection we visited the starlight ward, paediatric assessment and observation unit (PAOU), day case unit, the neonatal unit and surgical theatres. We spoke with 11 parents of patients from the neonatal and paediatric ward and five young people with their carers. We observed care and treatment and reviewed 18 nursing and medical records on starlight ward and 20 on the neonatal unit. We spoke with 30 members of staff including nurses, junior doctors, consultants, ward managers, play specialists, domestic assistants, health care assistants, administration staff and senior managers. Prior to our inspection we reviewed comments from people who had contacted us about their experience at the hospital and we also reviewed the trust's performance data.

Services for children and young people

Summary of findings

Overall we rated children's and young people's service as good.

The neonatal unit did not always meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). Nurse staffing levels on starlight ward did not reflect Royal College of Nursing (RCN) standards; an acuity tool on the starlight ward was not in use at the time of the inspection. We raised concerns with senior leaders, highlighting the need for more staffing provisions in both areas. Staff undertook extra shifts on a weekly basis to make the ward safe but this was not sustainable. It was evident that staff were overworked but many staff felt obligated to pick up more than three extra shifts to make sure the ward ran efficiently so that care was delivered safely. The percentage of consultants (26%) working in paediatrics was worse than the England average (35%). Staff felt there was a lack of senior leadership. Although staff were aware of how to escalate their concerns to their manager or matron at ward level, there was little evidence of direction or support to mitigate risks from the executive board because staffing levels had not been addressed on that day.

Documentation on the paediatric ward was poor. We also raised concerns about the transfer of nursing notes from the nurse led book. This book contained patient information and was used by nursing staff as a daily task list. After cross referencing the book with 16 medical and nursing case notes we found 10 patients notes did not contain information that had been written in the nurse-led book. These concerns were escalated to the executive team on the unannounced inspection The nurse led book also raised serious concerns about data protection; If the nurse led book was requested by a parent this would also contain information about other children. This information was not coded and was not redacted once the book was completed.

Transition arrangements for children between 16 and 18 years were found to be rigid with all children over 16 years admitted to the adult services. This included children and young people admitted with mental health or self-harm concerns and also included young people with learning disabilities. The adult service used the integrated care pathway and escalated risk pathway however this pathway had been designed for adult patients.

However, all medicines were stored and checked appropriately, fridge temperatures were checked daily and there were processes in place to make sure fridge temperatures remained within a safe range. Staff were competent in their roles. Mandatory training, including safeguarding, was above the trust targets. Ward and theatre staff were all trained to look after children and babies and overall the service offered a good skill mix of staff who were European paediatric life support trained (EPLS) on starlight ward and new born life support (NLS) trained on the neonatal unit. The service offered simulation sessions on how to perform cardiopulmonary resuscitation (CPR) on children or how to fit a tracheotomy to all clinical staff but none had been arranged in the paediatric ward because staffing levels did not allow staff attend the training. Low staffing levels permitted staff from participating in external courses and attending away days and often staff undertook extra shifts to alleviate staffing pressures. It was evident that this had become the normal and there was no indication of senior managers assessing the situation to address the issues.

Multidisciplinary and departmental meetings were held amongst all areas of the service. Meetings were regular and were used to explore ideas to improve the patient pathway. They were well attended by senior clinicians and ward managers, safeguarding and other teams. The service was proud of their togetherness and gave several examples where service had improved following these meetings. For example to ensure there were enough beds for patients who presented at the paediatric emergency department (PED), the paediatric day case unit offered staffing support to the paediatric assessment and observation unit. This improved the access and flow pressures in the PED.

Children received compassionate care and were looked after with dignity and respect. Families were consulted with and actively took part in developing their child's

Services for children and young people

care plan. We observed staff being empathetic and supportive towards children and their families, and carers did not hesitate to approach staff if they had any concerns.

The local leaders on the ward and units were visible and managers were actively involved in the day to day running of the paediatric areas. However we noted that managers undertook clinical duties to increase staffing numbers which consequently meant they had limited time for managerial duties. Staff were motivated in their roles and worked well together to deliver a quality and efficient service. There was a strong focus on delivering safe patient care and managers supported staff to develop their skills. However, staff were not always able to attend workshops or training sessions because of operational pressures and time was limited. The service lacked direction and support from the executive board level; this was evident from the staffing provisions at the time of the inspection.

Staff actively engaged with the public, they offered meeting groups, for parents of children and babies using the services, as a way to bring them together and share experiences. Changes to practice and policies were cascaded through staff meetings and emails. Staff used the trust wide newsletter to announce achievements to other services and used the service operations meeting as a route to approach senior managers.

Staff in all areas strived to provide a robust service for children and their families. We saw examples of innovative projects that revolutionised care for children with different needs. In July 2015 the cystic fibrosis (CF) team won the first National Cystic Fibrosis Registry Quality Improvement Award in recognition for innovative use of the Port CF database, which focused on early intervention to prevent further deterioration in their patient's condition.

Are services for children and young people safe?

Requires improvement

We rated the safe services for children and young people as requiring improvement.

Staff were aware how to report incidents on the Hospitals Electronic Reporting System (HERs); however it was not evident that staff were knowledgeable about the types of incidents to report and we witnessed one incident which was not appropriately escalated or reported during the inspection. We found that not all staff were familiar with what constituted an incident. During the inspection we observed two further occasions where incidents had occurred and had not been reported, despite reminders being given to staff, these included poor documentation and low staffing levels.

Nurse staffing levels on the paediatric ward did not reflect Royal College of Nursing (RCN) standards (August 2013). The service reported 11 incidents relating to "insufficient staff to manage workload" between November 2014 and October 2015. Whilst on the inspection nurse staffing on the neonatal ward did not meet British Association of Perinatal Medicine (BAPM) on two occasions. We were assured on both occasions by leaders that staffing was safe according to the acuity of patients on the ward and informed that two patients was due for discharge. The percentage of consultants (26%) working in paediatrics was worse than the England average (35%).

The children and young people's consultant clinical service lead also had responsibilities as the children's safeguarding lead. Safeguarding policies and procedures for children were in place but level three training uptake was low. Staff were aware of their roles and responsibilities and knew how to escalate any safeguarding concerns appropriately. In 2015 the trust upgraded their Female Genital Mutilation (FGM) guidelines to a policy, making reporting FGM a mandatory requirement as per national recommendations.

Transition arrangements for children between 16 and 18 years were found to be rigid with all children over 16 years admitted to the adult services. This included children and young people admitted with mental health or self-harm

concerns and also included young people with learning disabilities. The adult service used the integrated care pathway and escalated risk pathway however this pathway had been designed for adult patients.

The environment was dull and tired, however whilst on inspection we saw that walls were being painted and funding for a new floor had been approved. The equipment was electronically checked and cleaned. The resuscitation equipment was consistently checked by staff throughout 2015/16 and we found equipment was readily available.

All areas were visibly clean; staff were seen adhering to current infection prevention and control guidelines. Hand gels and sanitizers were available and were being used by staff. The ward and unit achieved above the trusts hand hygiene target of 85%, the audit showed 95% of staff were compliant.

Medication was labelled and systematically stored. We checked controlled drugs in the paediatric ward and the neonatal unit, which we found to be appropriately locked away and the keys held by a designated member of staff. Fridge temperatures across the wards were consistently checked and recorded by staff. We noted on occasions when the fridge ranges were not in safety parameters, staff checked an hour later to make sure the temperature was safe.

The ward and the unit assessed patients using the paediatric early warning score system, this was evident in case notes we reviewed. A safety thermometer was used on the unit and ward. It was displayed clearly for the team to view. The unit and the ward closely measured hospital acquired harms and the proportion of patients that were 'harm free'. Data displayed whilst on inspection consisted of pressure ulcers, falls, urinary tract infections and MRSA or Clostridium difficile. Information relating to harms were displayed including information on falls, self-harm, tissue viability, complaints, and infection control and pressure ulcers.

A variety of clinicians attended the monthly mortality and morbidity audit meetings and minutes of the meetings were produced so that areas of learning could be identified.

The ward had a clear and robust major incident plan, this was regularly reviewed and practice scenarios had been carried out previously to identify any gaps in the plan. The major incident box could be located on the ward, it contained a plan, high vis jackets, and information booklets for people with defined responsibilities.

Incidents

- The children and young people's service reported 376 incidents between November 2014 and October 2015. Trust data showed that 199 incidents reported related to the neonatal unit and a further 176 incidents were related to the paediatric ward, with the majority of incidents categorised as minor or low harm. The service recorded a combination of 60 incidents relating to the incorrect administration, dispensing and prescription of medication, this was the highest category of reported incidents These incidents were reviewed and actions were documented and discussed with staff. These included staff being asked to revisit and read the trust policies relating to wrongly administrated medication and for pharmacy to review their practice. Staff involved were asked to attend a training session on fluid management.
- Staff were aware of how to report incidents on the Hospital's Electronic Reporting System (HER's), when staff reported incidents, managers reviewed them and took appropriate responsive actions. However it was not evident that staff were knowledgeable about the types of incidents to report. Whilst on inspection we observed incidents that were not reported. An example of this was 24 hours after a child had fallen, the matron was unaware of the incident, it had not been reported on HERs and it was not in the patient's notes. After the matron became aware of the incident, it was reported on the HERs system and the actions to reduce this from occurring again were addressed.
- Managers shared lessons learned from incidents with staff through emails and safety huddles. We were given examples of how improvements were made to clinical practice and how staff received feedback. For example an incident relating to the incorrect administration of a medication was fed back to staff during the ward safety huddle and at a team meeting with the pharmacy and the prescriber.
- There was a positive approach to reporting incidents on the neonatal unit; staff gave examples of when practice had changed because lessons had been learned from incidents. For example failure to safely prescribe led to a two checker drugs system being implemented and staff

having to sign the patient record. Additionally failure to identify pressure sores led to increasing staff awareness about how to reduce the risk of sores developing and how to care for them. Lessons from incidents that involved medication errors had led to new documentation for advance practitioners to use and improving the handover.

- Not all staff reported receiving the trust wide incident alert email; however we saw evidence this was also available as a paper copy which included an overview of all incidents rated as red or amber. Incidents were also displayed on the ward notice board; the information highlighted the error, the action and the learning points.
- The service reported two serious incidents between October 2014 and September 2015. The service had undertaken root cause analysis investigations for these incidents. We reviewed the root cause analysis investigation reports for both incidents and found that the investigations were appropriate, proportionate and managers had taken appropriate action in response to the incident. This meant that the risk of a similar incident occurring again was reduced.
- The neonatal team attended the perinatal morbidity and mortality meeting alongside the maternity team. Patient care and pathways were discussed; the adverse outcome, learning points and recommendations at the meeting were documented.
- From November 2014 to October 2015, the trust included the Duty of Candour (DoC) regulation within the Incident Reporting and Management Policy. However the new risk and governance team identified the need to separate the Duty of Candour policy and a review of current systems and processes were required to monitor compliance. In January 2015 the trust developed a standalone policy for DoC which included systems and processes to ensure services were open and transparent. Paediatric band five, six and seven nurses and medical staff were all aware of the importance of being honest and transparent with parents if something went wrong.

Cleanliness, infection control and hygiene

- All areas were visibly clean and treatment rooms were well organised.
- Hand gel and sanitisers were readily available on entry to each clinical area and as you entered the ward. Signage above sinks displayed the correct way for staff, patients and visitors to wash their hands. The display boards were clear and visible reminding visitors to wash their hands to reduce the risk of infection.
- The trust reported no Methicillin-resistant Staphylococcus aureus (MRSA) of Clostridium Difficile (C Diff) cases on Starlight ward between April 2015 and September 2015.
- All areas regularly achieved above 95% in hand hygiene audits. In October 2015, both the neonatal and paediatric ward achieved 100% in the trust wide hand washing audit, patient shared equipment audit and hand gel usage audit. This was evident in our observations. Staff in all areas were observed adhering to current infection prevention and control guidelines such as “bare below the elbow” guidance and hand washing.
- Domestic staff used cleaning schedules which were available in all areas and signed on a daily basis to identify the schedule had been adhered to.

Environment and equipment

- The ward and neonatal unit we visited had controlled access on both external doors. Patients and visitors were able to enter the ward through the main entrance or the paediatric assessment and observation unit, both entrances were manned by the receptionist. The day case area could be entered through automatic doors.
- The paediatric ward was dull; however the ward was being painted at the time of the inspection and we were advised that the floor was being replaced.
- The paediatric ward housed two emergency resuscitation trolleys, all the equipment on the trolleys were in place and records showed that both trolleys were checked on a daily basis. Recording logs indicated that staff actively checked the trolley and it was safe.
- The High Dependency Unit (HDU) within the ward was close to the main nurse’s station, so patients who had more complex needs and needed additional care were visible to the clinical staff. The room accommodated two beds although the ward was funded for one; staff told us that the second bed was placed in the room and used in extreme circumstances. However the service had not reported any incidents whereby the second bed had been used and this was not on the risk register.
- All medical equipment had been checked and labels indicated when they were next due to be serviced.

- The handling, storage and disposal of clinical waste including sharps followed protocol. All storage areas were labelled clearly so that staff could find equipment.

Medicines

- All medications in fridges and in cupboards were labelled and systematically stored. Medication that had been opened was dated so that staff were able to discard them if they exceeded the expiry date.
- Medicines were stored correctly and consistently checked twice a day as per the trust's policy. Fridge temperatures across the wards were consistently checked and recorded by staff. We noted that on occasions when the fridge ranges were not in safety parameters, staff checked an hour later to make sure the temperature was safe.

Records

- We reviewed 20 sets of patient records on the neonatal unit and found all were completed to a good standard. All records had documented evidence of patient observations, diagnosis and management plan. There was a clear medical plan for each child documented and evidence that discussion had taken place with family members.
- We reviewed 16 patient records on the paediatric ward and found that 12 records were incomplete and of a poor standard. Patient identification was missing on documentation and information was missing from the care plan such as the seizure chart.
- During the ward round, the consultant was accompanied by the nursing team, as part of the process a nurse-led book was completed to record the test and investigations ordered during the ward round. However on review of the medical and nursing records it was evident that the medical and nursing staff were not recording tests and investigations they ordered. Upon cross referencing the book and the notes, it became apparent that daily practice was reliant on the nurse-led book and not on the patient's care plan. We raised concerns with the ward manager and the nurse in charge. Of the 16 records we reviewed, 13 did not contain information of the medical notes or tests and investigations ordered and therefore the records did not identify the needs for a follow up. As a result of bringing the issue to the attention of the Chief Nurse and Executive Director of Risk and Governance, a system was implemented on 12 February 2016 to ensure that all clinical staff fully documented all the discussions, changes to treatment plans, tests and investigations ordered in the medical records as per best practice. Senior managers advised that a daily audit of medical records against the information held within the nurse led book commenced on 12 February 2016. This was to be reviewed daily by the Paediatric & Neonatal Matron and the shift coordinator in their absence.
- Prior to these changes we found no evidence that senior managers on Starlight ward had addressed poor documentation on the ward. A documentation audit that took place in 2015 showed that 61% of notes were incomplete. The audit findings were presented to ward staff and staff were asked to complete documentation, with the view to re-audit in the future.
- The neonatal nurse led book containing patient details was left out in public view. The unit manager was asked that the identity of patients were coded or that the book was kept in a locked cupboard. During the unannounced inspection we observed staff on the neonatal unit use the nurse- led book, however on this occasion it was kept in a locked trolley.
- Care plans were stored in lockable cupboards behind the nurse's station.

Safeguarding

- All staff in contact with children, young people and their families were aware of their roles and responsibilities to report safeguarding concerns and to promote the wellbeing of children. Staff in all areas were familiar with the trust's safeguarding policy and could locate it on the intranet.
- As part of the ward admission processes staff asked if children had an allocated social worker. Staff completed a children's wellbeing form upon admission to the ward.. By doing so, staff were informed of the child's background. In patient records we reviewed, staff had referred patients to the safeguarding team as soon as they were aware of any issue. The safeguarding team stamped and dated the notes as confirmation of the referral and assessment.
- All staff were confident in identifying the potential indicators of abuse and neglect in children and told us they knew how to act on their concerns.
- Safeguarding training formed part of the trust's mandatory training programme. The trust had a target of 85% and data indicated that all staff on the neonatal unit and 97% of staff on paediatric ward had completed

level two safeguarding children training. Level three training was required for all clinical staff working with children and young people. In November 2015 only 77.6% of staff on the Starlight ward were level three trained, all neonatal staff were level three trained from January 2016.

- Children aged between 16 and17 years old were put on an adult ward with no option of being admitted to the children's ward, this included children and young people admitted where mental health and self-harm concerns had been identified and also included young people with learning disabilities. The ward would use the integrated care pathway and escalated risk pathway; however this pathway was for adult patients.

Mandatory training

- All staff received mandatory training in areas such as infection control, fire safety, medicine safety and emergency planning. Training was delivered via various methods such as on-line and face to face sessions.
- The trust target for compliance with mandatory training was 85% and records showed that mandatory training compliance rates for the paediatric ward was 95% and 96.4% for the neonatal unit.

Assessing and responding to patient risk

- A safety thermometer was used on the unit and ward. This allowed the ward and unit to measure hospital acquired harms and the proportion of patients that were 'harm free'. Such harms could be; pressure ulcers, falls, urinary tract infections and MRSA or Clostridium difficile. Information relating to harms were displayed information on falls, self-harm, tissue viability, complaints, and infection control and pressure ulcers. Senior managers and nursing staff were aware of the information on the safety thermometer. The information was updated weekly by the ward manager or matron. In January 2016, the ward reported one fall, one self-harm incident and one pressure ulcer.
- A retrospective case note audit of 58 patients who attended the children's ward between January and December 2008 was carried out to review how reliable the Paediatric Early Warning Score and Paediatric illness severity assessment tool was at assessing those children needing admission to HDU. The audit found that the combination of both tools was most effective. We found no evidence of a more current audit taking place and therefore it was unclear if the assessment tools were still effective. However we did note that the paediatric early warning score was regularly used to clinically assess patients and observations were carried out routinely and recorded clearly.

Nursing staffing

- The paediatric ward was staffed with five trained nurses between 07.00 and 20.00 including a co-ordinator and four trained nurses between 19.45 and 07.15. There was also one healthcare support worker on each shift.
- Nurse staffing levels on the paediatric ward did not reflect Royal College of Nursing (RCN) standards (August 2013). The matron and ward manager did not staff the ward according to the Royal College of Nursing guidance on nurse to patient ratios. The staffing requirements of shifts on the Starlight ward by senior managers were determined without using an acuity tools. Staff told us that the Starlight unit had tried to incorporate an acuity tool based on a model used by a specialist children's hospital, but this had proven difficult to adopt due to the wide range of fluctuating criteria and rapid turnover of patients.
- The ward had not been adequately staffed on a number of occasions. Staff picked up extra shifts on a weekly basis to make sure the ward was safe, this way of working had become the norm but this was not sustainable. Staff reported staffing issues as incidents; "insufficient staffing to manage the patient workload" was reported four times by staff in the neonatal unit and seven times by paediatric staff. Staff worked on a 1:8 nurse to patient ratio and told us they felt' burnt out' this was evident with the level of sickness across the ward of 5.36%, 218 of 290 units across the hospital trust reported a lower sickness rate.
- The starlight ward and neonatal unit displayed their establishment and actual staffing levels on the ward. The starlight ward 'RAG '(red, amber and green) rated their registered nurse one day and night fill rate which was 82% for days and 70.6% for nights. These rates were highlighted red, which indicated that shifts were not filled appropriately. We found no evidence that this was being addressed, we did find that staff were working extra shifts to help with staffing shortages.
- Staffing on the paediatric observation and assessment unit was staggered and reflective of when the area was most busy. It was staffed with four trained nurses

between 07.00 and 20.00, 9.00 and22.00, 12.00 and 01.00 and 19.45 and 07.15. On inspection the staffing levels were safe and adequate for the number of patients on the unit.

- Day stay Services were staffed with 7.6 whole-time equivalent (WTE) trained nurses and 3.8 WTE health care support workers. On inspection the patients seen on the day stay unit were seen in a timely manner.
- The nursing handover was informative, all staff nurses and the play specialist attended. The play specialist was present so that she could capture who needed play therapy and when. This was so that play specialist could be coordinated amongst the team and children were seen at times they needed distraction such as children who were going to surgery. We listened to a high level discussion between staff; which included an overview of each patient's acuity, complaints, staff sickness, pharmacy issues, updates relating to outpatients department, the assessment area and discharge. Issues relating to the unit were discussed at safety huddles to increase awareness amongst staff. We observed a more detailed patient handover at the bedside, which meant that staff could be introduced to patients and gain clarification about the patient's clinical needs.
- Nurse staffing on the neonatal ward did not meet British Association of Perinatal Medicine (BAPM) standards on two occasions during the inspection. Concerns of safe staffing were raised with the unit manager on both occasions. However, we were assured on both occasions that staffing levels were safe by the unit manager who had addressed the shortage by undertaking clinical duties and assessing which patients were fit for discharge.

Medical staffing

- The percentage of consultants (26%) working in paediatrics was worse than the England average (35%). The percentage of middle grade doctors was 62% which was better than the England average of 51% and 9% of the medical staff were junior doctors which again were better than the England average of 7%.
- The service had separate paediatric and neonatal consultant 'hot weeks' who provided cover from 8.30am-5pm for inpatients and emergency admissions. There were separate consultant 'on call' rotas for the paediatric and neonatal units. The ward and unit had consultant presence 08:30-20.00 during the weekdays. At weekends there were also two consultants 'on call', each being present on site for at least five hours.
- We observed medical handover at 8.30am on the paediatric ward, the handover was informative and it was consultant led. The medical staff used a structured proforma to inform the team about the acuity of the patients. The handover was patient focused and clear.

Major incident awareness and training

- The trust had a robust major incident plan which listed the key responsibilities of people in the department. The policy was updated in June 2015.
- Emergency planning was pivotal to the service; we were shown the delivery plan and minutes of a planned mock scenario that took place in May 2014.
- We were shown the major incident box, which was located on the ward, and contained a number of items such as folders that contained instructions for individuals with designated roles and tabards.
- There was a clear management system that ensured managers knew how to locate beds in the hospital.

Are services for children and young people effective?

Good

We rated the effectiveness of services for children and young people as good.

Staff effectively managed the service, they were familiar with policies and procedures which reflected current national guidelines and best practice.

Children were assessed for pain routinely, the Wong- Barker Faces pain rating scale was used to help children communicate information about their pain. We noted that the chart was displayed behind all the beds in the unit.

The nutritional and hydration needs of children were assessed by staff, the weight and child's age was clearly written, so that staff could measure appropriate levels of fluids. The care plans reviewed on the unit all contained fluid charts that were completed.

The service participated in regular local and national audits. There were positive outcomes for children; the

national diabetes audit showed that more children had controlled diabetes within acceptable limits. Blood sugar level monitoring were slightly lower (68%) than the national average (72%). The neonatal unit were actively collecting data for the baby friendly 2016 audit. Audit of the WHO Safer surgery checklist in children conducted between April and October 2015 demonstrated over 99 and 100% compliance. The rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma between July 2014 to June 2015 was 14.3%, this was better than the England average of 16.8%.

Staff were competent in their roles and worked well as part of a multidisciplinary team. Communication was good amongst the multidisciplinary team which was evident during ward rounds and handovers. Staff sought appropriate consent from patients and those close to them before delivering treatment and care. Staff used the Gillick competency and Fraser guidelines (used to decide whether a young person is mature enough to make decisions), where appropriate, for example with consent for treatment to balance young people's rights and wishes with the responsibility to keep children safe from harm.

Staff had access to patient information electronically across the children's and adult services; this helped with transitioning a child to adult services. Discharge letters were electronically sent to GP's at discharge to ensure that they had access to information about the inpatient stay.

The service provided a seven day service across radiology and pharmacy, however children's mental health services was limited to a five day service.

Evidence-based care and treatment

- All staff were familiar with current guidance; for example the British Association Perinatal Medicine (BAPM) guidelines to staff their unit and to make sure the cot space was safe; however we found that staffing did not always meet BAPM standards.
- The paediatric ward used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment provided such as the pathway for diagnosing conditions including hypoglycaemia.
- The neonatal unit was level two Baby Friendly accredited and was signed up to the Bliss baby charter. We were shown the initial stages of the Bliss baby charter audit; however the unit had not yet gathered any data but were in the process of collating information.
- The unit was actively promoting breastfeeding; the trust was awarded full accreditation for being baby friendly in 2011 and were due for reassessment in 2017. Trained nurses on the unit delivered support and advice to parents according to baby friendly guidance.

Pain relief

- Pain was managed effectively. We spoke with five parents of children in the ward and Paediatric Observation Assessment Unit (POAU), and they all confirmed that their child was given appropriate pain relief. Additionally we observed children being regularly asked if they needed any pain relief.
- The Wong- Barker Faces pain rating scale was displayed behind all the beds in the unit. This smiley face tool was used to help children communicate information about their pain

Nutrition and hydration

- Fluid charts were routinely updated in all areas of the children's service, the weight and age of the child was written clearly for staff to use when calculating fluids. The service had robust training relating to fluid management for all clinical staff .The paediatric ward displayed the weekly breakfast, lunch and dinner choices so that children could choose in advance what they wanted.
- Small snacks such as toast and fresh fruit were available at any time on request.
- Sandwich options were provided in 'child friendly' packaging and staff endeavoured to find alternatives for children if required
- Children were involved in improving the menu choices, long term patients were asked to sit on the panel and taste new food options.
- Formula milk in the neonatal unit milk room was in date and stored in date order. The milk kitchens contained sterilised packaged teats used for formula feeding.

Patient outcomes

- Audit of the WHO Safer surgery checklist in children conducted between April and October 2015 demonstrated over 99 and 100% compliance.

- An audit was completed in 2015 to identify if pain assessment tools were used on the ward and if appropriate subsequent prescribing and administration of pain relief was carried out. Results showed surgical pain management was poor, 15 surgical notes were reviewed, analgesia was prescribed in all case notes but less than 20% of notes had a fully completed pain assessment chart, 11 had missed doses and six had no Paediatric Early Warning Score (Pews). Actions to improve patient outcomes were put in place. A new "face style" pain chart was introduced in each bed area which we observed in practice. A new version of the pain assessment tool was introduced, and was part of the pain care plan.Nursing staff had received training to manage pain and how to use the new tool. The ward had planned to re-audit pain management in 2016.
- The service was involved in national and local audits to improve their performance.
- Cystic Fibrosis patient data was reviewed to improve patient care and compliance with NICE guidance. The information identified if a patient's lung function increased when given an intervention that supported their daily regime. The service found that by complying with daily regime, patients increased their lung function over a 12 month period. For example a declining lung function of 60% in one patient increased to above 80%.
- The service reported a higher percentage of patients with a blood sugar measurement of HbA1c less than 7.5 in the 2013/14 Paediatric Diabetes Audit (21.8%) compared to the national average (18.5%). The median blood sugar levels were slightly lower (68%) than the national average (72%). This indicated that more children had diabetes controlled within acceptable limits.
- Trust data showed that there were no emergency readmissions after elective surgery amongst patients under one year old between June 2014 and May 2015.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma between July 2014 to June 2015 was 14.3%, this was better than the England average of 16.8%.

Competent staff

- All staff we observed were confident and knowledgeable in their roles. We spoke to band five, six staff and health care assistants who all felt supported to learn and develop their skills.
- The practice educator was meticulous at identifying gaps in training and appraisals. Annual appraisal rates for staff on starlight were 98.25% and 89% on the neonatal unit; this was above the trust target of 85%.
- Staff on the starlight ward were confident in caring for children, 78% of staff were European Paediatric life support trained (EPLS), with a further four nurses were to attend the training in February 2016. The EPLS qualified healthcare professionals were trained in the early detection of respiratory or circulatory failure in children. Staff who had undertaken the course were familiar with preventing further deterioration towards respiratory or cardiorespiratory arrest.However there were only three members of staff that were newborn life support (NLS) trained. This meant if a newborn baby was to arrest on the ward and the NLS trained nurses were not on shift a nurse from the neonatal unit would have to be called. Whilst on site it took more than five minutes to walk from the neonatal unit to starlight ward and therefore in an emergency this would delay this support. All the staff on the neonatal unit were New-born life support (NLS) trained
- The neonatal unit had been decommissioned from a level three unit to a level two unit. However staff were given the opportunity to rotate across the three different rooms; Intensive Care Unit, high dependency and special care. The unit often cared for babies who needed level three care until their transfer had been arranged, by doing this nurses were exposed to different levels of care.
- On the neonatal ward, new staff were supernumerary for three months and worked only on the special care area whilst they gained their competencies.
- Medical staff felt they received a good supportive induction. During induction they were given a pharmacy competencies workbook which ensured they became familiar with paediatric specific medication issues. The workbook was returned to the paediatric pharmacy lead, who reviewed it and gave feedback on an individual basis.
- Medical staff used the medical round as a method of learning; they often presented at the meeting and used it as a valuable teaching and learning session.

Multidisciplinary working

- Multidisciplinary team working was good. Staff we spoke with in all areas of the service confirmed that

there were good working relationships between medical and nursing staff. All teams regularly communicated with each other as well as other departments such as maternity or radiology.
- A multidisciplinary meeting was held in the neonatal unit once a month. We reviewed meeting minutes that showed the meeting was attended by paediatricians, midwives, governance and risk managers and the matrons.
- There was little input from the child and adolescent mental health services (CAMHS) team. Children who were referred for an assessment were usually seen within 48 hours unless they were referred to the team on a Friday. If a child needed a metal health assessment this was not done over the weekend and the patient waited until Monday unless it was urgent.
- Clinical and nursing staff told us that play specialists were pivotal in providing additional information about the child's mental ability, they did this by assessing the child whilst they played, they used the opportunity to observe and talk to the children in a non-clinical area.
- The children's services promoted joint working across paediatrics and adult services to eventually give the patient the independence he or she requires to look after their own health needs.

Seven-day services

- The service provided a seven-day service across the paediatric ward, the neonatal unit, x-ray and the paediatric assessment and observation unit.
- Consultant on-call cover was provided out of hours.
- If a child needed a metal health assessment this was not done over the weekend and the patient waited until Monday unless it was urgent.

Access to information

- Staff had access to policies and procedures, which were all kept on the trust's intranet and. when asked, staff were familiar with how to access them.
- Staff had access to the Portacath database, this database held paediatric and adult patient information and was used across the hospital. Staff in the children's service accessed the database for clinical audit purposes, planning transition effectively and a variety of other purposes such as reviewing prescribing practice, discontinuation or commencement of medication.
- Discharge letters for infants from the neonatal and paediatric unit were informative, they contained information regarding medication and were sent electronically to the GP. This was to ensure the GP was aware of the patient's health condition after the patient was discharged.

Consent

- We observed clinicians taking consent from parents before assessing children during ward rounds. Staff spoke to parents and children and young people about any care and treatment that was being carried out before they went ahead with the procedure.
- Staff across the service were aware of appropriate procedures in obtaining consent. They described how they established if a child could make their own decisions and understood the implications of treatment by using the Gillick competence and Fraser guidelines.

Are services for children and young people caring?

Good

We rated caring as good in services for children and young people.

Good care was seen in all areas of the service. We observed all staff showed compassion and empathy whilst interacting with parents and their children. Nursing staff on Starlight ward were altruistic; they often came in to provide entertainment for children on their days off, so that children did not miss out on festivities such as the Christmas pantomime or the Easter bunny trail.

Parents confirmed they felt their child was safe and cared for with dignity and kindness. This was corroborated with the feedback the service received and the efforts made by staff to continuously improve their service. The wall boards displayed the unit and ward's activity such charity events. All parents we spoke with said they could not fault the care their child received.

Staff involved parents and worked alongside families to understand their needs, ranging from religious beliefs, other family commitments such as younger children and work. Play specialist were pivotal to understanding the

needs of a child, they often picked up what the child liked and disliked through play. Clinical staff relied on the play specialist team to siphon vital information that would help them when treating and caring for that child.

The NHS Friends and Family test showed that over 90% of parents were happy with the care their child received in the children's services. Feedback from the service was used to drive forward improvements, staff were aware of the issues raised and worked to mitigate any concerns.

Compassionate care

- The care we observed was good. We observed that patients were treated with kindness and respect. Staff expressed compassion and positively spoke about their role. Staff adapted their practice to meet the needs of their patients. For example when a patient needed heart surgery the unit made her a pink blood pressure (BP) machine to take to school, so that she could use it on her friends as a way of overcoming her phobia.
- The interaction between staff in all areas was positive and patients and their families were positive about their relationships with staff. We spoke with 11 parents who all said that staff were helpful and they felt confident with the staff caring for their child.
- We observed curtains were closed around patient's bed areas when staff were providing personal care to protect patient's dignity.
- We were shown areas on the ward where staff could speak to families privately, in order to maintain confidentiality.
- Staff took time to interact with patients and their families. They were attentive to their needs and spoke in a compassionate manner. We spoke with five young people on the ward and their families who all gave positive feedback about the attitude of the staff who attended to them. A family of a long term patient told us the staff went the extra mile for the children on the ward. Staff staged a Christmas pantomime in their own time for children over the festive season.
- The ward participated in the NHS Friends and Family test; however the response rate was low at between 8% - 27% between April (8%) and September 2015 (27%). The test indicated that between 94% - 98% of participants would recommend the women and children's unit. The trust achieved their target of 97% in August and September 2015.
- The neonatal unit participated in the NHS Friends and Family test, 100% of families who took part recommended the service.

Understanding and involvement of patients and those close to them

- Staff on the paediatric ward worked with each other to make sure they captured all the needs of their patients, for example the play specialist listened in to early nurse hand overs to take note of which patient needed their input. By doing so they used opportunities through play to ascertain information about the child's likes, dislikes, phobias, routines and behaviours.
- Staff identified when patients required additional support; for example they liaised with the cystic fibrosis (CF) specialist nurse to engage with CF patients and their families so that care could be tailored to their needs.
- We observed the medical ward rounds on the paediatric ward which included input from nursing staff and the play specialist. The medical team spoke to older children and their parents about their condition and treatment.
- Neonatal unit staff informed parents about treatment and care. We heard them update parents with the progress of their baby when they telephoned into the unit. Parents spoke positively about the information staff gave to them verbally and in the form of written materials, such as information leaflets specific to their condition and treatment.

Emotional support

- Children with complex and long term health needs were supported by specialist nurses. For example the CF team had started a support group for parents of CF patients, the diabetes nurses and psychologists had started a separate group to support families with children who had recently been diagnosed with diabetes. These groups offered parents the chance to share experiences with families who were familiar with the condition.
- Staff demonstrated that they understood the importance of providing children and their families with emotional support. We observed staff providing reassurance to anxious children and comfort to relatives.

Services for children and young people

- Play specialists were available Monday to Friday and supported patients undergoing procedures on the ward. Play specialists involved siblings when preparing play sessions so that patients could play in a normal setting, where possible.
- Parents with babies in the neonatal unit told us that staff supported them with their emotional needs. For example staff encouraged parents to care for their baby such as bathing and feeding them in preparation for discharge.

Are services for children and young people responsive?

Good

We rated the responsiveness of services for children and young people as good.

The service was responsive to the needs of the patients they cared for. Children and young people were at the centre of care and clinical practice. The ward showed ways of adapting their practice to help children and their families feel comfortable and reassured. Children theatres were located near to the ward and televisions were placed in lifts to entertain children when they were being transported to and from theatre. Parents of neonates were offered rooming in facilities to help them gain confidence when caring for their baby.

The Starlight ward had a wide variety of activities for children and young people to do and the facilities were tailored to specific age groups. The play specialists were visible from 7am and were utilised on a daily basis; they were especially good at helping clinicians with anxious children and ascertaining information from children through play. The service was able to meet the individual needs of patients and their families.

Clinical and nursing staff were attentive to the requirements of children and their parents. The service responded to timely waits in the accident and emergency department and closed beds in one area to allow staff to move to the paediatric assessment observation unit to improve the length of stay on the ward. Senior managers were aware that the paediatric and surgical paediatric referral to treatment times had not been met and are looking at ways to achieve the trust target of 85%.

Specialist teams such as the Cystic Fibrosis team were informed about patients on the ward to ensure their care plan could be individualised.

We were shown leaflets that were offered to parents, which were available in different languages upon request. Wall boards displayed information about conditions and medication in all different formats. This was so that adults and parents could read and understand symptoms and treatment.

However, there were delays in accessing specialist beds for children requiring Child and Adolescent Mental Health Services (CAMHS). CAMHS involvement was poor, which often meant that children were not assessed during the weekend.

Service planning and delivery to meet the needs of local people

- Children, young people and their families were engaged with and involved in the development of the service. For example children were asked to comment on menu choices to better meal provisions and parents helped shape the patient passport. The passport was given to children who had complex conditions, parents and staff worked together to form the passport to make sure it included a summary of the children's conditions.
- The environment on the paediatric ward was not appealing or child friendly; however this was being addressed and, whilst on inspection, the ward was being painted.
- There were a variety of toys available for different age groups, with games consoles, DVD'S and board games being available. Whilst observing a nurses' bedside handover where a patient expressed they were bored, we observed the nurse find a television unit which incorporated a DVD player and games system for the young person to play with.
- There were six play specialists that worked across the service between 7am-6pm. The play specialists were available to all patients and often helped clinicians with distraction. A play programme was planned for long term patients to avoid boredom and developmental assessments were carried out to help children gain skills.
- The Starlight ward was divided into the paediatric ward and the paediatric assessment and observation unit. Children were accommodated by coloured bays for example the green bay was for toddlers and the blue

bay was for teenagers or CAMHS patients. However this was the ideal and was not always the case. If the department became busy, patients would be allocated a bed where one was available.
- There was a dedicated paediatric theatre that was close to the ward, the theatre was child friendly and the lift taking children to theatre had TV's in the ceiling. The theatre was separate from adult and obstetric theatres.
- The special needs nurse and ward manager for the children's services told us that they held regular meetings to assess whether the services needed to change. For example a passport was introduced for patients with special needs. This was given to patients and completed on admission and was then kept with the patient at all times. The passport contained information about the patient's siblings, medication, likes, phobias and admissions. The service introduced this so parents wouldn't need to keep explaining their child's needs at every admission and to enable staff to find all important information about the patient in one area.
- Patients with a complex condition were given open access on to the ward to reduce their waiting times.
- The ward had introduced a new policy and training for parents of CF patients to administrate antibiotics at home. This was implemented so that patients could be cared for in the comfort of their own homes rather than a hospital environment.
- The theatre area used for paediatric surgery had a dedicated recovery area; the lifts contained televisions in the ceiling, so that children could watch programmes whilst they were transported to and from surgery.
- Parents who stayed overnight with their child were given a 'camp bed', there was a separate parent's room with a shower room, seating and kitchen area.
- There was a separate room for mum's to express milk on the neonatal unit. The unit encouraged mums to breastfeed and express milk, when mums struggled to express, support and assistance was available.
- Meals were provided for breast feeding mums, and there was a café and shop in the hospital for visitors to use.
- Parents of children in the hospital were provided with a 'parking token', which reduced the cost of parking at the hospital
- The play room was also available to siblings of patients on the ward, play specialists welcomed siblings and set up play for them and the patient.
- There were two side rooms, which contained a double bed and ensuite facilities on the neonatal unit. These rooms were offered to parents whose baby was ready to be discharged. By "rooming in" parents had the support of the clinical staff during the night. This was to help parents feel more confident with looking after their baby prior to discharge.
- On the neonatal unit the parent's area had a seating area, with a television and kitchen. The area contained leaflets on an array of information such as financial support. Parents were encouraged to visit whenever they wish. There was a separate room for Mum's to express milk.
- If their child was on the unit, parents were provided with a 'parking token', which reduced the cost of parking at the hospital

Access and flow

- In August 2013, a 24 hour paediatric and observation assessment unit (POAU) was opened following a service review into the access and flow in the children's emergency department.
- Although the has noted a small reduction in the length of stay in POAU from 6.3 hours in December 2014 to 6.2 hours in December 2015, the ward managers propose that this reduction will continue and help manage patients more quickly.
- The service closed four beds in the day unit to allow the paediatric assessment and observation unit to open a further four beds. This change allowed staff to be moved to the PAOU at busy times and consequently the access and flow from paediatric emergency department (PED) to the ward or discharge improved from 2014 to 2015. In 2015 the length of stay on the ward for patients who were transferred from POAU was 52.9hours compared to 64.2 hours in December 2015.
- The service had worked towards reducing the number of readmissions for asthma patients; specialist nurses had been appointed to develop pathways for asthma patients. Multiple readmission rates for asthma in 1-17 years old was 14.3%, which was slightly lower than the England average of 16.8%.
- Multiple readmission rates for epilepsy and diabetes were not available as the overall number of patients treated was low.
- The current paediatric referral to treatment time (RTT) was (75%) and the RTT for paediatric surgery admitted pathways was 82%, both areas were not achieving the

trust's referral to treatment (RTT) standards of 85%. The clinical lead was aware of the referral to treatment times and actively reviewed them at the operational management meeting. The service had plans in place to address the current performance and an epilepsy strategy was being written to address the 10 week waiting times. However we did not see the draft version of this. An allergy nurse had been appointed to address the RTT for patients with an allergy which was up to 14 weeks at the time of the inspection. By appointing a designated nurse, managers believed that this would reduce waiting times.

- The neonatal unit had a robust discharge pathway and tools were in place to monitor the baby's growth. Information such as weight and feeding intake was discussed with parents, so that parents were informed of what mile stones were needed to be achieved before their baby could be discharged home. We were shown the discharge planning board which was visible in the special care room. All capabilities listed on the discharge board needed to be completed before the unit discharged babies.
- Between February 2015 and April 2015, 22 children and young people reported mental health concerns, of the 22 patients, six patients were not assessed by the CAMHS team from a neighbouring trust. This trust did not record the reasons why patients were not seen and therefore could not provide us with any information. The Mental Health Team (MHT) and the Children Adolescent Mental Health Service (CAMHS) assessed 12 (67%) of the remaining 18 patients in the Accident & Emergency department, nine of these patients were seen whilst 'on call' and three patients during "normal hours" Monday – Friday 9-5pm. The service lacked CAMHS visibility and involvement. CAHMS only assessed 2 patients who were admitted during "normal hours' with self-harm or suicidal feelings, but did not assess the 4 patients admitted during 'normal hours' with intentional overdoses.

Meeting people's individual needs

- The children and young people services were responsive to the needs of children and those close to them. They had organised their services to meet the different needs of the patients they treated.
- We found an array of information leaflets about services and treatments readily available in English in all the areas. Leaflets in different languages or other formats were available on request. We saw examples of information leaflets in different languages such as Polish and Punjabi. Staff showed us where leaflets were on the intranet and advised patients that they were available on request. The play specialists were developing a child friendly leaflet about coming into hospital. We were shown feedback forms that children have completed about what the leaflet should include and how it should look like.
- There was a direct dial facility for telephone interpretation; staff could fill in an on line request form or telephone the provider directly, if required.
- An adolescent room called "the teen zone" for the older children and a bright play room for the younger children was available. The play specialists provided support and activities for the children and their families. During term times there was a school on the ward, which had recently been inspected by Ofsted and was rated outstanding. A specially equipped 'sensory room' was located on the ward. This purpose built room contained soft flooring, lights and an air bubble machine, it was used for children with special needs or if parents wanted to relax with their children.
- The service offered transitional pathways for children who were ready for adult services. Children were placed on a "Ready Steady Go" transition plan from the age of 15 years old, (a three-stage plan to support children and help them gradually grow confidence and skills to take care of their own health care). However the age the patient transitioned over to adult services varied depending on their health and mental health needs, some patients stayed with the children services up until 25 years old.
- Cystic fibrosis and diabetes teams had established separate transition pathways, both teams started discussions with young people and parents from the age 12, with the view to transfer patients who have complex needs to adult services from between 16 and 19 years of age. For example children with diabetes were introduced to a transition diabetes nurse (TDN) at around the age of 15 years, whilst under the care of the paediatric diabetes team, the TDN liaised with both the young people's team and the paediatric team to organise joint clinics. Transition documentation was completed by the paediatric team, and shared with the adult services to inform the adult team of the child's clinical and personal needs, patients were asked to attend the adult centre.

Services for children and young people

- The service offers transition clinics 4-6 times a year which were held in the paediatric out patients department. Patients were offered 45 minute appointments with a healthcare professional such as a YPs consultants, the transition nurse, YPs nurse and psychologist.
- The purpose of all clinics was to provide help to patients, discuss their care and support the needs of the parent/guardian(s)
- The paediatric service had close links with the Manchester CAMHS Service this was part of a neighbouring trust to support the care of mental health patients. The CAMHS service provided a Monday to Friday service to complete assessments on the ward and follow ups, for all Children and Young People who have been admitted with mental health concerns The ward had separate side rooms for patients with mental health conditions but could not provide 1:1 care because of staffing pressures.
- The children's play room was spacious and welcoming to children, it offered a wide range of toys and play options for children to choose from. The room offered a variety of activities to choose from, these changed on a daily basis. The play room was open to siblings so patients could maintain an environment that was close to home or a nursery setting. The ward also offered a sensory room, so that children with sight or hearing difficulties were stimulated.
- The chaplaincy team and volunteers visited wards throughout the week to offer spiritual and/or religious support.
- Patients and their families were offered the opportunity to take part in religious services at appropriate times which included Holy Communion, communion at the bedside, Friday Jummah Prayers, Buddhist meditation, weekly quiet time.

Learning from complaints and concerns

- 'Raising concerns' forms were used in the neonatal unit and completed by shift coordinators if an informal complaint was raised. We noted that the unit addressed concerns immediately, for example parents informed staff that communication was poor amongst the medical team. This was discussed at the safety huddle and clinicians started to proactively inform parents about their baby's care and treatment plan. Forms were stored in a locked filing cabinet.
- Both the neonatal and paediatric ward displayed learning from complaints. The paediatric ward reported no complaints between August 2015 and January 2016. One complaint was reported on the neonatal unit, this was actioned by the unit manager, the complaint and lessons learned were discussed at the neonatal safety huddle and the staff involved were given support and guidance.
- Complaints posters detailing information on how to complain were displayed across all units.
- Leaflets about how to raise a complaint and details about the complaints procedure were available for patients and visitor in all areas.

Are services for children and young people well-led?

Good

We rated services for children and young people as good for being well-led.

Staff on the ward knew how to escalate risks to their managers. Ward managers undertook risk assessments to evaluate the workload and followed the escalation process to mitigate potential risks but there appeared to be a lack of senior management response to the concerns raised. Senior managers were aware of the current staffing risks in the department but as a result management time for the ward managers was not protected. Consequently, this limited their ability to address managerial duties and they were working hours outside their weekly contracted hours or late to complete managerial tasks such as appraisals. It was evident that the service received limited executive oversight which left the service open to avoidable risks. As part of our inspection we raised concerns about documentation and staffing on Starlight ward and the Neonatal unit. On the unannounced inspection it was apparent the trust had started to address the staffing issues on Starlight ward; however shortfalls still remained.

All staff were aware of the service vision which was "to provide family-centred care appropriate to the needs of children, young people and their families" but they were not as familiar with the trust wide vision and mission statement. The leadership on the ward was good, the ward managers and the clinical leads were directive, supportive

and visible. Medical and nursing staff spoke highly of their managers and acknowledged that poor morale on the ward or unit was consequently because of poor staffing and not a reflection on the team.

Senior managers actively reviewed the quality and performance of the ward. The data covered sickness rates, hand hygiene audits, admissions to the paediatric assessment and observation unit (PAOU) and High Dependency unit and readmission rates on both the neonatal unit and starlight ward. Incidents were thoroughly reviewed by managers and regularly documented and cascaded to other areas of the service to avoid the incident from occurring again. We noted that managers were aware of the current referral to treatment rates (RTT) and plans were in place to reduce waiting times.

Clinical directorate meetings took place monthly and were well attended by service managers and clinicians. Staff were keen to make sure the service was safe and would pick up extra shifts to alleviate staffing pressures.

The ward and neonatal unit demonstrated joint working amongst staff nurses and senior managers. There was a cohesive approach to determining ward activity between medical and nursing staff, senior managers actively sought involvement from their team about concerns such as capacity of the ward or accepting new admissions on to the ward.

Staff received trust wide information through emails and leaflets attached to payslips, achievements were shared via the newsletter and the ward mangers used team meetings to keep staff involved and up to date with changes to local and trust wide practice or policies.

The culture within the service was positive, teams often engaged with each other and respected one another. We saw many examples of unified team working and commitment from staff in sometimes difficult circumstances as a result of busy periods or operational pressures.

Staff worked hard to keep the public engaged, they participated in fundraising activities to raise money for equipment on the ward. The neonatal unit held monthly meetings for parents to share neonatal experiences. Their commitment to the children they looked after was appreciated by parents and this was corroborated with the feedback the service received from both parents and children.

The service was working towards providing better care for children with complex needs. They had appointed a diabetic and cystic fibrosis nurse and were currently looking to strengthen their awareness about epilepsy. The paediatric team were proud of their cystic fibrosis work and in July 2015 the paediatric CF team won the 1st National Cystic Fibrosis Registry Quality Improvement Award in recognition for innovative use of the Port CF database to provide focussed and early intervention to prevent further deterioration in their patients.

The service would like to offer other provisions to children and their families such as breastfeeding support and a one stop tongue tie clinic for babies. At the time of the inspection there was one trained nurse that has completed the training to treat tongue tie, the view was to train other nurses.

Vision and strategy for this service

- Managers and staff were proud of their vision “to provide family-centred care appropriate to the needs of children, young people and their families”. They worked together to provide safe care for their patients. However staff were not as familiar with the trust wide vision and mission statement.
- The trust had recently been told that they had not been identified as a specialist hospital for surgery and emergency services for the “Healthier Together Programme” in Manchester, this had affected morale in the service and staff told us they feel unsure of how the children's service strategy will look in years to come. Senior managers on the ward reassured staff about their job roles but there was no evidence of the executive team informing and assuring staff about the future of the service.

Governance, risk management and quality measurement

- The clinical lead, ward and unit manager proactively reviewed the performance of their service; during these meetings they discussed incidents, actions, staffing and the local needs of the population they serve.
- The quality and performance of the children's service was monitored weekly by senior managers, the data covered sickness rates, hand hygiene audits, admissions to the PAOU, the High Dependency unit and readmission rates on the neonatal unit and starlight ward.

- Safety huddles across the children's service took place twice a day which gave staff the opportunity to discuss any risks they had about patients on the ward.
- We raised issues about staffing with staff and managers on the ward and unit, they all had recognised nurse staffing was an issue however despite shortfalls in the staffing rota this was not recorded on the risk register at the time of our inspection.
- The outpatients department reviewed information such as appointment cancellations and DNA (Did Not Attend) rates regularly.
- The paediatric liaison meeting was held monthly, senior managers who attended this meeting discussed the activity on the department. We reviewed minutes from these meetings and found that actions were set and completed in a timely manner
- Senior managers from the daycare unit, neonatal unit, paediatric observation and assessment unit and the paediatric ward met on a monthly basis to discuss the operational issues and needs of the service. This multidisciplinary meeting allowed staff to manage the demands of the service and help the flow of patients. For example senior managers on the day case unit took the decision to close 4 beds so that 4 beds on the PAOU unit could be opened. This was agreed to improve the flow of patients from the paediatric emergency department (PED) The length of stay reduced more than 10% in those patients who were admitted to the ward from the PED in December 2015 (44.4 hours) compared to December 2014 (57 hours) because they were managed and cared for appropriately.
- The neonatal unit held monthly meetings. We reviewed the minutes from December 2015 meeting; the meeting addressed how the unit could improve. For example staff were asked to fill weight and equipment charts and to stock the IV trolley appropriately. There was an energetic approach to mitigate risks and deliver of good care from the local management team. Incidents were thoroughly investigated by management and cascaded to other areas of the service so that any lessons learnt from the incident could be shared amongst staff with the view to prevent the incident from occurring again. For example an incident involving a GP being sent the wrong discharge letter was systematically investigated by the paediatric observation and assessment unit manager, the lessons learnt and the actions were clearly documented and nursing practice was changed to prevent the incident from happening again. We also noted that the duty of candour was followed by the unit, the parents were contacted and an apology was made along with an explanation and plan of how the error was revolved. We reviewed management documentation of incidents; they all followed the same methodology, presenting the incident, the lessons learnt and the actions. Ward management were keen on reflective learning sessions to improve how staff work.
- Members of the diabetes and CF teams as well as the respiratory nurse attended the transition steering group, which had regular meetings and training days to improve progress.

Leadership of service

- The paediatric service was led by the Head of Midwifery and Childrens Services, they were supported by a Matron and ward managers. The matron was new in post and the ward manager and deputy manager had been promoted from previous roles in the department.
- The local leadership of starlight ward and the neonatal ward was good and staff spoke positively of it. Leaders were visible, respected and competent in their roles. Staff within the starlight ward told us that the culture on the ward had improved since the appointment of the ward manager and that she was an inspirational leader.
- Management championed innovative ways to improve their service and the patient experience. The lead for children with complex needs, play specialist lead and the ward managers were passionate about reducing anxieties of the patients that use the service. The service introduced an open access and a passport for patients with complex needs. This contained information such as a summary of the patient's medical and family history, likes and dislikes and the admission history. By having open access to the ward and the passport, patients were not waiting unnecessarily and clinicians were able to access vital information whilst waiting for notes to arrive.
- There was a lack of leadership from the executive board, staffing concerns had been raised but not investigated or addressed. It was apparent that there was a disconnect between ward management and the executive team. Risks such as staffing had not been addressed.
- There was a safeguarding clinical lead and a named nurse on the ward for vulnerable children. Staff found it was helpful that there was a familiar "go to person" on

the ward if they had any safeguarding concerns. Alternatively staff did not hesitate to contact the trust wide safeguarding team if they could not locate the named doctor or nurse.

- The staff pulse survey was an intervention used to capture what staff said about their work place. The trust received 248 responses in the 2015 survey. The survey showed that staff did not feel supported in their job roles and there was little guidance and investment in learning. It was evident on inspection that the service had provisions to support staff with upskilling themselves. Equipment was available for simulation sessions but training could not be organised or attended because of staffing shortage.
- The Chief nurse and Executive Director of Risk and Governance was known to nursing staff and was visible but staff felt that the she was unaware of concerns at ward level.
- There was a clear escalation processes in place when assessing staffing levels and staff were aware of how to do this. The process clearly stated points to consider before escalation, these included reviewing and assessing risks to the unit or the ward. Staff were asked to check the dependency of babies and evaluate their workload.
- All staff showed flexibility and willingness to pick up extra shifts at short notice to make sure the ward and unit was safe. However staff sickness rates on the paediatric were high 5.36% compared to 241 other areas in the trust, the trust reported 49 other areas had a higher sickness rate
- Junior medical staff felt that they had strong leadership and guidance from consultants and the pharmacy department; they were closely monitored and found it easy to discuss concerns with them. The play specialist leader was visible on the ward, new staff were all introduced to the play specialists and a short presentation about their role was given. Health care assistants were offered the opportunity to attend a workshop that taught them how to distract children. A competencies framework would be signed before they were allowed to take on play duties.

Culture within the service

- The culture in the children and young people's service was good, medical and nursing staff were actively engaged with each other.
- Teams communicated effectively and worked well together. We observed open communication dialogue across the departments which helped staff care for their patient effectively. For example staff told us if a patient was unwell in the outpatients department, they would arrange for them to be seen by one of the paediatric doctors in PAOU. After the initial assessment, if the patient needed admitting the transfer was coordinated rapidly.
- Staff were committed to providing high quality care in circumstances that were uncertain and difficult such as changes in senior management and low staff numbers. Shifts had become normalised and staff had adapted to unmanageable working conditions to keep staffing levels safe. This affected morale on the ward, staff enjoyed working as a team but felt that the circumstances they worked under were not ideal
- All staff told us that after changes in senior management, they now felt confident in raising concerns or any issues they had with their managers.

Public engagement

- The service routinely engaged with patients and their relatives to gain feedback about how they could improve their service.
- Parents of neonates were invited to a monthly group called "twinkle toes", the meeting was started as a peer support group for parents to share their experiences. In October 2015 only four families attended, the low attendance was due to school holidays so the unit decided not to have a meeting in October next year. In November 2015, 14 families attended the meeting. We reviewed summary minutes of both meetings, parents discussed their baby's progress and information was shared about breastfeeding.
- The paediatric department used "tops and pants" to gain feedback about their service from a child's point of view. Children wrote the positive and the not so positive things about the ward. All feedback was clearly displayed near the nurse's station and subsequent actions were taken.

Staff engagement

- Senior managers recognised that staff morale had been low in the department and therefore held regular meetings with staff to inform them of changes and activity on the ward. By doing this staff felt involved and used the opportunity to raise any concerns they had.

- The staff on the ward raised money for equipment through sponsorship. The team raised money for children and young people on the ward, for example families and patients were given gifts at Christmas and Easter.
- The services and trust also engaged with staff via email, newsletters attached to payslips and through other general information and correspondence displayed on notice boards in staff rooms

Innovation, improvement and sustainability

- Staff were keen to develop their service to improve the care they offered children and their families. For example following the death of an autistic patient at the hospital, clinical leads identified areas of improvement, the service has planned to raise the awareness of autism, support staff to care for children who are autistic by offering training.
- The cystic fibrosis team were awarded the quality improvement award by UK cystic fibrosis registry annual meeting in July 2015. The paediatric CF team won the first National Cystic Fibrosis Registry Quality Improvement Award in recognition for innovative use of the Port CF database, which provided focussed and early intervention to prevent further deterioration in their patient's condition.
- The ward introduced the use of 'High Flow' oxygen; warmed humidified oxygen which was given to children to reduce the need for HDU and CPAP. In 2015 a 'fabian' ventilator was introduced which enabled the ward to provide bilevel positive airway pressure BIPAP and continuous positive airway pressure (CPAP) in larger children (up to 30 kg). By offering children the high flow or Fabian ventilator the ward reduced the need for invasive ventilation, this was a recent intervention and comparative data was not available at the time of the inspection
- The ward manager in PAOU had completed 'The Advanced Clinical Skill in Tongue-tie' course and planned to offer the course to other nurses so that the service could provide a nurse-led clinic to assess and treat babies with tongue-tie.

End of life care

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

Information about the service

The University Hospital of South Manchester NHS Foundation trust end of life care service included the specialist palliative care team which was an integrated hospital and community team, the trust's multi-faith chaplaincy service, the patient experience team, porterage bereavement team and histopathology services.

There was a Macmillan care centre in the hospital and specialist palliative care outpatient support was available at the Neil Cliffe centre situated in the grounds of Wythenshawe hospital.

The service referred patients to St Ann's hospice based in Stockport and the Marie Curie home sitting service.

The hospital based Macmillan and supportive palliative care team consisted of 11 full and part time specialist nurses, one part time nurse consultant and two part time medical consultants. The team worked 8.30am to 4.30pm seven days a week. During 2014 -15 the team saw 1453 referrals which included patients with skin cancer, pulmonary cancer and upper gastrointestinal cancer.

The community team consisted of five full and part time specialist nurses, two part-time medical consultants, two allied health care professionals and a social worker. This team worked between 8.30am and 4.30pm five days a week.

The trust provided a specialist pulmonary oncology service.

Summary of findings

Overall we rated end of life care as good because:

The trust responded to practice changes in relation to replacing the Liverpool Care Pathway and in June 2014 introduced the 'Individual plan of care for people who are dying' (IPoC). This was based on 'Five priorities for end of life care' developed by the Leadership Alliance for the Care of Dying People.

The specialist palliative care team and other services involved in end of life care were caring and took steps to maintain patient dignity and comfort. Processes were in place to provide emotional and practical support to the patient and their family. There was provision for people with communication difficulties, this included an interpreter service.

Multiagency working was well established and processes were in place to enable patients and relatives to be involved in advance care planning. Preferences were observed when possible and cultural and religious needs were taken into account.

The trust provided a seven day a week specialist palliative care service in the hospital. The local hospice provides an out of hours advice line to hospital staff, district nurses and GPs'.

End of life care

Processes were in place to ensure senior doctors were able to assess the patient's needs using the five priorities. Medication to control the symptoms of end of life (anticipatory medication) were prescribed in good time.

Areas for improvement were identified in relation to some aspects of person centred care when prescribing medication, assessing pain and supporting people to die in their preferred place of death. The medication administration record did not differentiate between whether medication was been given for pain control or to relieve shortness of breath. This meant that the medication record could not be interpreted without referring to the medical or nursing notes. Although an initial pain assessment was completed and medication prescribed, staff did not routinely score the level of pain described by the patient using the tool provided. This meant the effectiveness of pain control was not monitored in line with best practice guidance.

The trust participated in a number of local, regional and national audits and re-audits to identify areas of effective practice and improvement. They were proactive in developing and implementing action plans to improve adherence to best practice guidance or develop new ways of working. This included monitoring whether end of life care was consistently delivered against the 'five priorities of the dying person', preferred place of death and access to palliative care services. Audits, plans and checks could be improved if targets dates for the completion of projects were always identified.

Do not attempt cardio-pulmonary resuscitation documentation was consistently completed to a good standard. Staff understood the systems in place for escalating safeguarding concerns and demonstrated a good understanding of the Mental Capacity Act.

Nurse managers and senior medical staff who led services involved in end of life care in the trust were accessible to staff, patients and their relatives. The trust's 2015 -2020 strategy for end of life care was in draft stage and should be expedited, however, strategic work to improve services were on-going.

The trust had introduced customer satisfaction processes and acted on information provided by patients, relatives and staff. The trust should consider a staff survey aimed at palliative care and end of life staff to assess staff satisfaction with the standard of care they provide and for working for the trust.

We visited 13 wards, the multi-faith centre, the chaplaincy service, the chapel of rest, the mortuary and the bereavement office. We spoke with nine patients and relatives. We also talked with 52 members of staff from all departments involved with providing end of life and palliative care services. We reviewed the trust's performance data.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

Staff were encouraged to report incidents and there were systems in place to monitor and act upon incidents reported, however some staff such as porterage staff did not have access to the electronic reporting system. We saw evidence that incident reports from staff that could not access the system had been acted upon.

Processes were in place to make sure palliative and end of life patients received timely care and treatment, which met their needs.

Records were well maintained and provided sufficient information about the care and treatment offered to patients.

The medication administration record (MAR) for end of life medication was unclear and required review.

Medical, nursing and ancillary staff were available in sufficient numbers to ensure people receiving palliative or end of life care were looked after safely.

Incidents

- Six incidents were reported between November 2014 and October 2015, four were 'no harm' and two were 'minor'. Records indicated these had been reviewed by senior staff. Direct feedback had been provided to staff who were involved and action had been taken.
- Doctors, nurses and allied health care professionals were aware of their responsibility to report incidents through the trust's electronic incident reporting system.
- Porterage staff could not enter incidents on to electronic system, which indicated that incident reporting might be incomplete.
- Porterage and technical staff said that not all end of life incidents were reported through the electronic reporting system. For example, moving and handling incidents that had taken place in 2015 were not reflected in the trust's end of life incident records November 2014 to October 2015.
- The trust had taken action in response to verbal reports and feedback provided at meetings. Acton taken included improving moving and handling equipment in the mortuary.
- Lessons learnt from incidents in the trust were shared through the trust intranet pages, at meetings and through publications.
- Duty of Candour legislation requires senior staff to disclose safety incidents that result in moderate or severe harm, or death. A duty of candour policy was in place and the specialist palliative care team had provided Duty of Candour workshops to all grades of staff. No duty of candour incidents had been reported for end of life services.

Cleanliness, infection control and hygiene

- Mortuary, viewing areas and family facilities we visited were clean, well maintained and fit for purpose.
- The mortuary technicians were responsible for cleaning clinical areas. Cleaning schedules were in place and records indicated cleaning had taken place as required.
- Staff areas in the mortuary were not visible clean at the time of inspection. It was unclear who was responsible for cleaning staff areas and the frequency of these arrangements.
- Appropriate personal protection equipment (PPE) such as gloves and aprons was available in ward and mortuary areas to prevent the spread of infection. Staff were aware of the policies and procedures for using PPE, and we observed staff used these appropriately. Hand cleansing gel was provided for use between visits for staff working in a community setting.
- Community palliative care team did not wear uniforms the trust should enforce the bare below elbows dress code in the community, as this is best practice guidance for all staff coming into contact with patients.
- Local audits were completed to check how well staff complied with trust infection prevention policies and the standard of cleanliness achieved in the mortuary. For example the mortuary - health and safety audit November 2015 achieved partial compliance in five areas and the corresponding action plan printed in January 2016 indicated that by December 2015 action had been taken to make all areas compliant.

Environment and equipment

End of life care

- The trust responded to staff suggestions about updating the environment for example replacement of flooring in the post-mortem room had been included on the end of life risk register and a financial case discussed at governance meetings.
- Syringe drivers used to administer medication were available from stores in the hospital. These could be accessed 24 hours a day. The hospital palliative care team also held a small number in their office. These were used to support prompt transfer of care for patients wishing to be at home. We checked a sample of the drives at the office. The equipment was labelled as clean and the service sticker indicated maintenance checks were in date.
- The same model of syringe driver was used throughout the trust, which meant staff in different settings could operate the device.
- Mandatory and induction training for nurses and doctors included training on the safe use of syringe drivers. All the medical and nursing staff indicated syringe drives were readily available.

Medicines

- Doctors received training about safe prescribing in end of life care. Detailed guidance was provided on the wards and on the trust intranet site which was readily accessible.
- Most palliative care nurses were 'nurse prescribers' which meant they had been trained to prescribe specialist medication. This meant patients could receive additional medication quickly.
- Community nurse prescribers worked closely with GP's and local pharmacists to ensure that patients received prescribed medication appropriately.
- A palliative care pharmacist was responsible for ensuring specialist medication was available on all wards. Wards we visited had appropriate drugs available to support patients.
- Patient's prescription charts showed that medicines for palliative care had been prescribed and administered within local administration guidelines.
- We found that medication administration records were difficult to interpret. This was because medication used for both pain control and shortness of breath were recorded in the same section. This meant it was not possible to identify on the chart why a medication was being given. The trust was made aware of this finding at the time of the inspection visit.
- In the community, blank prescriptions forms were not managed in accordance with NHS best practice guidance. This was because forms were not signed out and nurse prescribers did not keep a record of the serial numbers of prescriptions used. NHS best practice guidance about the security of prescription forms recommends; maintaining a record of the serial numbers of prescription forms carried and limiting the number of forms taken on home visits to 10 or less.

Records

- The palliative care service used paper records these were well managed and stored securely. The service planned to change to the trust wide electronic records keeping system when this was embedded.
- Do not attempt cardio-pulmonary resuscitation' (DNACPR) paperwork had been completed appropriately. Completed forms were filed at the front of medical notes in the hospital or community nursing notes so that staff could access them easily.
- We reviewed 20 sets of records and information indicated that decisions about resuscitation were discussed with the patient or relatives. Forms had been completed in full with the exception of one doctor who had not included their General Medical Council (GMC) number and designation.
- Written reports indicated that information had been provided to patients and their families about end of life care.
- Most records viewed were neat and tidy. Reports and letters were filed uniformly, entries were legible.
- In most cases, staff recorded their name in block capitals, their signature and designation. This meant a clear audit trail of staff involved with the patient was provided.

Safeguarding

- Safeguarding was included in yearly mandatory training. Data showed that 100% of palliative care staff had completed level one child protection and adult safeguarding training.
- The trust's target for level two safeguarding training was 85%. Data indicated that 80% of palliative care staff had completed this training.

- Nursing and medical staff knew how to recognise abuse and raise concerns; they described the process of contacting the safeguarding team and multidisciplinary working with regards to protecting vulnerable children and adults.
- Porterage staff completed a safeguarding information checklist during training and were able to describe how they would raise concerns.

Mandatory training

- Staff providing end of life care completed mandatory training. Over-all 'unscheduled care', the directorate which included palliative care services, achieved 86% compliance. Topics encompassed conflict resolution; learning disability awareness level one; safe handling of medicines in the community and equality and diversity.
- In response to the results of the 2015 national care of the dying audit from March 2016, the trust planned to add end of life care to the mandatory training program for all clinical and nursing staff.

Assessing and responding to patient risk

- In the hospital setting, risk assessments were completed for people who were receiving end of life care. Risk assessments included skin integrity; falls; moving and handling. Records were completed appropriately and acted on. It was also noted, however, that nutritional risk assessments were not always in place.
- All wards and community teams had a palliative care link nurse who escalated concerns to the specialist palliative care team (SPCT). Ward staff also indicated any nurse could contact the team and we observed the SPCT responding on the day to patient referrals emailed from the wards.
- Ward staff told us and we observed that the specialist palliative care team (SPCT) regularly visited wards to review patients.
- Any change to a referred patient's condition generated a visit from the SPCT. We saw that the team updated the patients daily records.
- Nursing, medical and therapy staff also recorded any change in the condition of palliative care and end of life patients.
- Junior doctors said ward staff were knowledgeable about palliative and end of life care. Doctors told us they had access to palliative care resource boxes which were available on the wards. These boxes contained a detailed flow chart and the documents needed to manage end of life care safely and respond to patient risk.
- Risk assessments were not always completed in the community, for example we saw a blank pressure area risk assessment on one file and there were no completed nutritional or pain assessments in the community files we reviewed. District nurses stated they did not always have time to complete detailed risk assessments for patients with complex needs.

Nursing staffing

- We found that there were sufficient palliative care nurses to support people during end of life care.
- The integrated hospital and community specialist palliative care nurses were led by a specialist nurse consultant, supported by a clinical nurse specialist team leader. In total there were 11 clinical nurse specialists working in the hospital. This number included Macmillan nurses and nurse specialists in particular conditions, for example skin cancer, upper gastrointestinal cancer and pulmonary oncology.
- The trust had introduced the role of 'end of life link nurse' on all wards and district nursing teams. These nurses led on embedding the trusts end of life strategy and raising awareness in how to provide appropriate care for patients in their area of work.
- Link nurses for nursing homes were also identified. The trust hosted a link nurse group which met alternate months. Nurses working in the hospital, community and nursing homes attended.
- The link nurses interviewed stated they were supported to complete this role.
- Specialist nurses provided a seven-day service to hospital patients. Hospital nurses were positive about the nursing establishment and skill mix. They felt well supported to provide a safe and efficient service. There were no vacancies on this team.
- At the time of the inspection visit the community team consisted of five palliative care community nurses. There were also two cancer and palliative care facilitators who provided palliative care training to district nurses and nurses working in care homes. Since the inspection the trust has approved funding to employ an additional full time palliative care nurse, an occupational therapist 0.4 whole time equivalent (WTE), physiotherapist 0.4 WTE and social worker 0.4 WTE.

End of life care

- The community palliative team worked closely with the nursing home advanced nurse practitioner and district nurses.
- The bereavement office included a qualified nurse to support the bereavement service. Staff indicated the role was invaluable because the team understood the needs of bereaved families and provided all patients with information about getting death certificates and dealing with the coroner's office.
- This post would become vacant in March 2016 and the trust was in the process of employing a successor.

Medical staffing

- There were two medical consultants leads for end of life and palliative care services. Other consultants supporting the service included a pathologist, clinical psychologist, respiratory, coronary and care of the elderly.
- Evidence indicated appropriate medical care was available at all times for end of life patients. We found that junior doctors from different departments were able to articulate the care and treatment required by patients during the final hours of life.
- Junior doctors were clear about accessing information and support. They described the training they had received and explained that guidance was available on a special palliative care intranet site. Information was easy to follow and adjust to facilitate individual needs.
- The consultants were an integral part of the weekly palliative care multidisciplinary team meeting.
- At these meetings the consultants met with hospital and community teams separately and made a decision on who required additional clinical input based on a joint discussion about symptom control.
- As part of ward handovers we saw that the needs of patients receiving end of life and palliative care was discussed.

Major incident awareness and training

- There was a major incident policy in place, which highlighted different levels of command depending on the seriousness of the event. This policy signposted to different plans for specific services including the mortuary services.
- Staff in the different services concerned with end of life care, for example, the mortuary manager, were able to articulate the processes for dealing with specific incidents. However, trust data indicated that clinical services, which included the mortuary services, scored amber in relation to major incident awareness. This was because although policies and procedures were in place these had not been tested.
- We saw that the mortuary hired additional equipment to cope with seasonal variations in demand for the service.

Are end of life care services effective?

Good

We rated effective as good because:

The trust ensured people received care and support in keeping with the most up to date best practice guidance and had replaced the Liverpool Care Pathway with the 'Five priorities' best practice guidance.

The trust audited the effectiveness of the service provided by the palliative care team and those involved in direct care of patients who were end of life.

The mortuary service completed a program of audits to check the technical and internal aspects of the service but did not complete audits about their interface with stakeholders.

Pain control was readily available however pain assessment tools were not routinely used and so there was risk of inadequate pain control.

The trust has introduced a new model of end of life care called the 'Individual plan for the dying person.' This was based on meeting end of life and palliative care best practice guidance.

Staff were appropriately trained and supported to provide end of life and palliative care.

Evidence-based care and treatment

- The trust had introduced systems to ensure patient care was consistently delivered using the evidence based guidance 'Five priorities of the care of the dying person' and the National Institute for Health and Care Excellence (NICE) guidance on End of Life Care for Adults.
- The trust stopped using the Liverpool care pathway in 2014. This had been replaced by the five priorities in January 2015. There were processes in place for

educating staff on best practice guidelines including workshops for all staff. Education was provided to all wards and departments including A&E, coronary care and intensive care.
- A palliative care resource box containing step by step guidance about the five priorities was provided to all wards, departments, community teams, GP practices and care homes. Guidance was also uploaded onto the trust intranet. Staff told us the resources available were useful.
- The trust had introduced an individual plan of care for senior doctors to use to ensure the five priorities were met for end of life patients. An audit of how well medical staff understood the five priorities of care and the need to use the care plans was conducted in September 2015. However consultants who are responsible for managing end of life care had not taken part in the audit.
- The audit indicated that junior doctors understood the principles of the 'five priorities' and followed them to ensure end of life services met with best practice guidance. Senior doctors had not participated in the audit.
- The trust had completed a local care of the dying audit follow-up in January 2016. The trust scored 100% in relation to plans of care including anticipatory medication to alleviate the symptoms. Medication was also prescribed in line with best practice guidance 100% of the time.
- The audit showed 100% compliance in recording in the medical records that the patient was end of life. The patients loved ones and family had been involved in planning care 100% of the time.
- This audit identified more action was required to ensure staff always completed reviews of: medication which scored 85%; nutritional needs which scored 60%; hydration which scored 80% and spiritual needs which scored 65%.
- It was explicit from speaking to senior nursing staff that the target for compliance in these areas was 100% however the trust had not set these targets or planned dates by which this would be achieved. This observation was discussed with senior staff.
- An early warning score assessment tool for end of life patients based on best practice guidance was being developed.
- Patients who had completed advanced plans of care kept a copy in their home.
- Out of hours services, NHS 111 and ambulance control were alerted through an electronic flagging system, fax and email about patients who were in the last days of life with DNACPR status.

Pain relief

- Medical and nursing records indicated patients received medication for pain as required. The trust ensured a plan of care for pain, which included prescribing anticipatory medication and taking action if the patient said they were in pain.
- While pain assessments for patients were taking place a pain scoring tool was not routinely completed. This meant the service could not be confident pain control measures consistently met individual needs.
- Specialist palliative nurses in the community discussed pain relief with patients and worked with the consultant in the community and the patient's GP to ensure patients received appropriate pain relief.
- Information in care records and medication administration records indicated medicines for pain were administered, then after an appropriate time period patients were asked about the effectiveness.
- Medication syringe drivers were readily available, community and district nurses could use them competently and anticipatory medicines were started quickly.
- In all cases, anticipatory medication had been prescribed. The trusts local care of the dying audit follow-up in January 2016 indicated 100% compliance for patients being prescribed medication for pain.

Nutrition and hydration

- Systems were in use to assess and provide nutrition and hydration to patients receiving palliative care. The patients we reviewed received appropriate nutrition and hydration in keeping with their assessed needs.
- We noted from charts and daily nursing records that all patients had received nutrition and hydration, however corresponding plans of care were not always in place. Patients had not been given a Nutritional Risk Score (NRS) assessment on admission to the unit. This was a five-step screening tool to identify adults who were malnourished, at risk of malnutrition, or obese.

Patient outcomes

- The trust's results from the 2013/14 national care of the dying audit for hospitals (NCDAH) indicated the trust

performed better than the England average in all but one clinical key performance indicator. The trust scored worse (57%) compared to the England average of (82%) in respect of the patients assessed in the last 24 hours of life.

- The trust scored better in all other clinical performance indicators for example: for multi-disciplinary recognition that the patient was dying the trust score better (90%) than the England average (61%); for achieving health professional's discussions with both the patient and their relatives/friends regarding recognition that the patient was dying the trust scored better (85%) than the England average (75%).
- With respect to assessment of spiritual needs of the patient and their nominated relatives or friends the trust scored better (40%) than the England average (37%).
- The percentage of patients prescribed medication to alleviate the five key symptoms that may develop during the dying phase was also better (77%) than the England average (51%).
- The review of the patient's nutritional requirements scored 81% which was better than the England average (41%) and review of the patient's hydration requirements scored (85%) which was better the England average (50%).
- Performance against key indicators were monitored through quarterly audits and reported through audit programme meetings. The trust's most recent re-audit in January 2016 showed improvements in information provided to relatives, provision of face to face access to specialist clinical support seven days a week and improvement in the telephone support provided out of hours in the acute hospital.
- The service had processes in place to support gold standard framework (GSF) accreditation in nursing homes. The GSF is a range of measures and quality assurance tools used to ensure that an evidence based approach is taken to end of life care.
- The trust leads the North West Audit Group (NWAG). The palliative care team submitted data for regional audits and re-audits which supported benchmarking with other trusts.
- The service completed local audits to evaluate patient experience for example the '2015 mortality report for deaths from secondary cancers'. This review indicated that people had received the correct care and treatment throughout their illness.
- The response to the results of local audits was not, however, always effective. For example, in 2012 the trust had completed compliance with the NICE guidance 140 opioids in palliative care. This showed the service only met one of the 10 standards. The re-audit in October 2014 showed a slow improvement in that compliance had increased from one to two out of 10 areas. It was shown that patients were prescribed correct medication for breakthrough pain and correct doses were also prescribed. The service, however, continued to score red in eight areas. The action plan was not robust and lacked urgency because plans did not include information about how improvement would be introduced before the two year review date.

Competent staff

- There was a comprehensive plan of training for all nursing and clinical staff to ensure they received appropriate training for their role. Evidence indicated that specialist palliative team nurses, community nurses, allied health care professionals and mortuary technicians had completed professional qualifications and appropriate post-professional qualification courses. The trust supported staff to continue their professional development.
- Staff from all areas indicated appropriate training opportunities were provided and ward staff said they received specialist training from the palliative team, which supported them in their role.
- The trust provided a comprehensive list of subjects covered through on line and classroom training, conferences, seminars and courses at local universities. Topics covered included advanced care planning.
- Records indicated that training and promoting staff competency in palliative and end of life care was a key achievement and discussed at senior level meetings.
- Specialist palliative care staff, the bereavement team and technicians indicated they received appraisals. Palliative care nurses indicated supervision was on going through working closely with senior staff. Data regarding appraisals was not available for the specialist palliative care team exclusively.
- The nursing home facilitator provided accredited end of life training to qualified nurses working in care homes.

Multidisciplinary working

End of life care

- There were detailed protocols in place to facilitate multidisciplinary working. The specialist palliative care team worked across all providers of services for example, hospitals, local authorities, hospices, GPs and charitable organisations.
- All staff spoken with confirmed processes were in place to support multidisciplinary working. Policies and procedures were in place for staff to follow in relation to their area of work and the need of the patients. For example a policy was in place for accessing an emergency ambulance to enable a rapid discharge out of hospital to the persons preferred place of death.
- There were weekly palliative care multidisciplinary team meetings attended by all staff supporting patients and families including nurse specialists, doctors and consultant, allied health care professionals chaplaincy, pharmacists and social workers.
- Members of the palliative team worked across different services for example one senior consultant supported palliative care and care of the elderly. This enabled expertise to be shared across specialities.
- There were effective working relationships with all wards and departments providing care and the team visited the clinical areas including the accident and emergency department every day.
- The trust employed three members of staff in the mortuary, a manager and two technicians. Senior managers used their professional judgement and assessed that the staffing was appropriate when compared to larger public mortuaries.
- There was also a team of therapists who worked from the Macmillan care centre who provided counselling, massage and other therapies.
- The trust employed a chaplaincy team to support people with and without faith with their emotional or spiritual needs as required.
- Records from meetings, information in plans of care, observations and feedback from relatives and staff showed effective multidisciplinary working between internal and external specialists involved in providing a service to patients receiving palliative or end of life care.
- There were clear protocols for transferring the patient from hospital to home and staff gave examples of when this had worked well. We saw that the service had an effective working relationship with independent care providers and accessed these services as needed.
- The trust liaised with GPs, social services and other service providers such as Marie Curie to ensure that people received appropriate care in their own home.
- There was multidisciplinary working between the trust and the chemotherapy day unit at specialist trusts. However, problems with transport from the trust sometimes caused a delay in patients receiving treatment.

Seven-day services

- The service provided palliative care support seven days a week 08.30 to 16.30 in the hospital, and outside of these hours there was the symptom control helpline based at a local hospice.
- The service provided palliative care support in the community five days a week at the time of the inspection. The service recognised the need for a seven day community service and this had been identified as a priority as part of commissioning discussions. People in the community were supported by the local hospice out of hours.

Access to information

- The trust was in the process of introducing an electronic record keeping system and the service intended to introduce the electronic palliative care co-ordination system once the trusts system had been embedded.
- There were no barriers to the specialist palliative care team accessing the patient's main medical and nursing records.
- In the community, the community specialist palliative nurses updated district nursing notes and amended the community held records which were stored at the appropriate health centre. This meant that all staff had access to information promptly to support patients.
- We noted that when a person died all records, including those from the community, were reconciled at the hospital and stored in a single file. These were also readily accessible.
- Do not attempt cardiac pulmonary resuscitation DNACPR forms and advance plans were held at home with the patient so that all staff were clear on decision-making.
- Doctors and nurses could access information about end of life on the intranet and information was also available on each ward unit in the palliative care information box.

End of life care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that staff gained consent from patients before carrying out observations and care.
- Staff we spoke with had an understanding of the Mental Capacity Act (MCA) and best interest decisions.
- Processes were in place to ensure relatives were involved in plans of care in keeping with the MCA and best interest guidance.
- The trust had undertaken an audit of a sample of DNACPR documentation in June 2015 and found that the documentation and communication of the decisions had been completed 100% of the time.
- We reviewed 20 DNACPR forms. We found that patients and or relatives had been involved in all cases and when the patient had not been involved the reason why was fully documented.
- All the forms had been signed by a senior doctor and a second signature was recorded when required. Not all signatures included the doctor's position and GMC number, as requested.

Are end of life care services caring?

Good

We rated caring as good because:

People using palliative care and end of life services were treated in a caring and compassionate way. Patients were treated with dignity and respect. A variety of therapeutic and counselling options were made available so that people could access support which met their needs. Patients and families were able to access spiritual and pastoral care which was non-denominational.

The trust provided emotional support for bereaved relatives and friends.

Compassionate care

- The trust participated in the bereavement survey for 2014/15 and the results from 103 participants were analysed. The survey found in total 98% of respondents were satisfied, and of these 75% were very satisfied, with the level of respect shown for patient dignity.
- We witnessed patients being treated with dignity and compassion on the wards we visited. We interviewed five relatives and patients and each praised the care and support provided by the palliative care team. A relative also noted improvement in care when the specialist palliative team became involved. The relative of a patient who had not been referred to the palliative care team was satisfied with the care provided by nurses and doctors on the ward.
- Staff indicated that there were no restrictions on visiting times for patients who had been officially assessed as end of life. This was identified through using the trusts criteria based on best practice guidance. This was confirmed by relatives.
- Deceased patients were treated with dignity and respect. Nurses and health care assistants received training in how to prepare patients for transport to the mortuary. The palliative care information box contained information about care after death. This information was in a folder titled 'End of Life staff training guides'.
- Descriptions in patients stories presented at governance meetings and evidence in letters from relatives indicated compassionate care was provided.
- Staff we observed were passionate about delivering end of life care and felt it was every body's responsibility to meet the patient's needs.
- Measures were in place to ensure patients were treated with care and respect. Porters and mortuary technicians indicated that dignity was always respected. The mortuary service did not request feedback from partner agencies about the service provided.

Understanding and involvement of patients and those close to them

- The bereavement survey found that 88% of people were satisfied, and of these 43% were very satisfied with the level of involvement in their relatives' plan of care.
- Evidence in medical and nursing records indicated that relatives and those close to people receiving palliative or end of life care were involved as appropriate. We noted that staff made an effort to contact close relatives of patents who did not live locally. Conversations were recorded in detail, which indicated the patient's relatives were able to voice concerns and make suggestions about how best to support the patient. On-going care records indicated relatives were listened to.
- Relatives said they were kept informed about care and treatment and we observed relatives been appropriately involved.

End of life care

Emotional support

- The bereavement survey found about 88% of respondents were satisfied, and of these 36% were very satisfied, with the level of emotional care. The trust was piloting a family initiative, which involved relatives completing a daily diary about emotional care with an aim to improving this result.
- The design of the integrated locality teams meant that where a patient's primary carer required additional support this could be assessed and arranged quickly.
- Emotional support was provided to patients and their families through a variety of services, including the voluntary sector. Community matrons and ward staff were able to refer bereaved relatives to the chaplaincy service for support.
- The bereavement team, Macmillan and specialist palliative care team stated they took time discuss the information provided when death certificates were collected by relatives. We were told that all relatives who wanted to view their relatives at the mortuary were provided with support from the bereavement team.
- The Macmillan centre provided a peaceful environment and trained volunteers were available to support relatives and patients who attended.
- There were a number of small gardens around the hospital grounds which were available for people to use as an area for reflection.
- Palliative care patients and their families had access to specialist complimentary therapy services provided at a specialist centre at the hospital.
- The trust used an established communication skills model designed to support patients and relatives in reaching their own solutions to issues and concern. Staff had received appropriate training in the process.
- Level two communication workshops were provided for medical and nursing staff responsible for completing advanced care planning with patients.
- The trust had a spiritual and pastoral care service which was non-denominational to offer support to patients and relatives. Faith leaders from most religions could be accessed. The service introduced different initiatives throughout the year and at the time of inspection was piloting a 'mindfulness' class for patients, relatives and staff.
- The chaplaincy were also sensitive to needs of people who did not subscribe to a belief system but welcomed a chance to reflect on their situation. Opportunities for one to one listening support was provided to relatives and patients.

Are end of life care services responsive?

Good

We rated responsive as good because:

Patients who needed specialist palliative care, advice and support received this quickly. The trust was responsive to the needs of the palliative and end of life patients in hospital. Processes were in place to provide equipment and care to people who died at home, however the proportion of people who died at home was significantly below the national average.Staff were encouraged to relate to patients and relatives to ensure they could respond to the needs of the patients, family and friends.The service shared positive feedback about end of life care with volunteers so that good practice was shared.The trust provided leaflets and booklets about the bereavement process and sign posted bereaved friends and families to support services such as self-help groups.

Service planning and delivery to meet the needs of local people

- Approximately 1,500 patients died within the trust each year. This figure was made up of patients in the community and Wythenshawe hospital.
- The trust participated in the 2014 preferred place of dying audit which looked at the percentage of people who died receiving care in the place of their choice, either at home, a hospice or at the hospital. 57 sets of patient's notes for patients who had given information about their preferred place of death were reviewed. The people had died between 05/10/14 and 11/12/2014.
- Only 53% of people who wanted to die at home had done so and 66% of patients who wanted to die in a hospice did so.

End of life care

- Discussion with senior palliative care staff indicated that decisions made about the place of death often changed due to family circumstances, the needs of the patient immediately prior to death or availability of hospice beds and this was not reflected in the place of death audit.
- The trust identified that action should be taken to enable more patients to die in their preferred place. The plans provided by the trust included improved collaboration between the trust and non-NHS providers to increase home support and strengthening policies to support people who wished to die at home.
- Palliative care and end of life care could be provided on any ward or clinical area. The trust provided robust systems and processes to ensure staff were aware of how to respond to palliative care and end of life patients. Visiting times on all wards were extended as appropriate. Equipment was provided to support patients who wished to die at home. Patients and families had access to sitting services and district nurse teams to ensure that patients and carers needs were met at home.
- The trust had developed a bereavement support professional forum open to all members of staff. The forum reviewed feedback from patients, updates from surveys and new ways of working. Initiatives from the forum included, leaflets and additional information for relatives and condolence cards sent to bereaved relatives from the pulmonary cancer service.
- Accommodation was used flexibly to ensure that relatives and patients' wishes were met and included reclining chairs so that relatives could remain with the patient as long as possible.
- Relative's accommodation was available on the pulmonary oncology and intensive care unit.
- The bereavement team had developed a memorial garden with the support of the league of friends. This was in response to national guidance recommending that outside space was made available to bereaved families.

Meeting people's individual needs

- The trust ensured choice was available to meet spiritual, religious and social needs. A multi-faith room was provided. Policies and procedures were in place to ensure religious rites such as prayers, washing or timely burials were facilitated.
- A palliative care psychologist was employed to support patients and families, and specialist counselling training was provided to nurses.
- Records indicated and processes were in place to ensure that staff were informed of advanced care plans at daily hand-over. These were discussed further during safety check meetings, which occurred at set intervals throughout the day.
- In response to the increased number of bariatric patients, the trust had purchased equipment to support patients, family and staff in ward and mortuary settings.
- Clear processes were in place for supporting people with a learning disability. The trust worked closely with a human rights legal group specifically engaged for people with a learning disability. This organisation supported the trust in developing easy to read documents to help explain relevant issues.

Access and flow

- In total the specialist palliative care service supported 2,560 patients between 2014 and 2015.
- The trusts referral audit completed in October 2015 showed that between July 2014 and October 2015, 95% of referrals were seen within 24 hours of referral, with 75% of these seen on the day of referral, this meant the service provided additional support quickly.
- The community Macmillan support and palliative care team saw 67% of patients within 24 hours of referral. The majority of referral were contacted within seven days and reasons for apparent delays investigated. This meant community based patients received additional advice and support quickly.
- All acceptance criteria was open and there were different referral routes into the specialist palliative care team. Accident and emergency flagged palliative care patients on admission and the information was picked up by the team. The team also visited the medical admissions unit daily.

End of life care

- Referrals were made by doctors and nurses on the wards. Patients and relatives could also self-refer.
- The team reviewed referrals daily and patients requiring symptom control and those for rapid discharge planning were given priority.
- Complex cases were worked jointly between senior and less experienced nurses.
- The hospital and community teams met separately each day to allocate work and then together at the weekly multidisciplinary team (MDT) meeting at which new patients and complex cases were discussed.
- Professionals involved in the MDT included the pharmacist, medical consultants, allied health care professions and other appropriate practitioners.
- The specialist palliative care team and ward staff told us not all patients who were dying were referred because many of the consultants and senior registrars were skilled at making sure end of life patients received good care and treatment based on best practice requirements.
- Information in medical and nursing records indicated appropriate medical care was provided when the palliative care team were not involved.
- We saw that the mortuary hired additional equipment to cope with seasonal variations in demand for this service.

Learning from complaints and concerns

- The service had not received specific complaints about palliative care, end of life or mortuary services. We observed that the complaints policy was readily available and the patient experience team were visible and worked closely with the Macmillan care centre, the specialist palliative care team and the bereavement team.
- Information indicated learning from experiences was used to raise awareness of all staff including volunteers, for example the patient liaison matron gave a presentation about positive feedback to the League of Friends.

Are end of life care services well-led?

Good

We rated well-led as good because:

The written strategy for the service needed to be reviewed and approved, however previous plans were on going and the trust communicated the core value of the service to staff.The quality of the service provided to people receiving palliative and end of life care was managed and reviewed at the highest levels in the trust.The direct managers and leadership team were visible and passionate about embracing and sharing best practice in palliative and end of life care.

Vision and strategy for this service

- Management of the five year strategy plans was robust because a report reviewing the outcomes for the palliative and end of life 2010-2015 strategy was available and highlighted goals which had been met, for example increasing the presence of the SPCT on the wards.
- At the time of this inspection, January 2016, the 2015-2020 strategy was still in draft form. Discussion with senior managers for the service indicated the delay in approving the plan was due to changes in commissioning and proposed restructuring. However, there was no clear target date for ratification.
- The trust had appointed a non-executive director to oversee palliative care and end of life service in 2015. This was in response to recommendations in the national care of the dying audit. The role is still to be embedded because at the time of the inspection a full walk around had not been completed by the nominated person.
- The trust had communicated core values across palliative care and end of life services base on the 'SAGE and THYME ®' model of communication developed in 2006 by clinical staff at the University Hospital of South Manchester NHS Foundation Trust (UHSM) and a patient. The model identified nine key considerations to improve the outcomes of conversations.

End of life care

- Staff described the services ambition as: positive communication, to demonstrate compassion and respect and meet the five priorities of care for end of life patients.
- All evidence including minutes from meetings, training plans and conversations with nursing, medical, allied health care professional, technical and ancillary staff with different levels of seniority, indicated that providing good end of life care had been made a priority.

Governance, risk management and quality measurement

- Clinical, palliative and end of life care at the trust was steered by the clinical standards subcommittee whose membership included senior medical and nursing palliative care specialists. Documents and records indicated the committee promoted the use of best practice, evidence- based care and treatment. One of the medical consultants was involved with the wider Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Strategy Group.
- Notes from governance and steering meetings indicated the clinical standards committee reported directly into senior board level meetings. The introduction of the revised end of life and palliative care processes were given a high profile at board level and launched at a 'Transform end of life care' event in July 2015. This was hosted by UHSM palliative care service and the NHS improving quality body.
- Mortality review meetings for patients that died at the hospital were attended by the palliative care consultant team, GP, governance team and nursing staff to identify learning for improvement.
- Audit reports and improvement plans for palliative care and mortuary services indicated there were comprehensive assurance and service performance measures in place which were reported to and monitored by the governance board.
- Action and improvement plans did not always include a timetable for activities or set targets for completion.
- The staff working in palliative and end of life services could describe the risks on the end of life risk register which was highlighted to the senior management board at director level. This indicated effective ward to board communication.

Leadership of service

- The leadership structure was clear for the Macmillan and palliative care support team.
- The leaders of the service demonstrated continued interest and drive to research and spearhead best practice developments. The service was influential because the lead nurse consultant was successful in sharing findings nationally through having articles successfully peer reviewed and published in highly respected end of life and palliative care journals.
- The clinical director and specialist consultant nurse, senior managers responsible for leading improvement, worked on the wards and in the community and so had direct experience of implementing plans. Staff told us there was good support and leadership for end of life care.
- Leaders within the service had engaged with partners and stakeholders with the aim of promoting seamless care for patients.
- Leadership for mortuary services were not immediately apparent.

Culture within the service

- We found an open and supportive culture in end of life care services, staff were engaged, open to new ideas and interested in sharing best practice.
- All staff we spoke with told us that end of life care was considered a high priority for them. They also stated that end of life care was an intrinsic part of their work for patients.
- The chaplaincy team were valued by staff it was felt support was available to help deal with emotional stress when required.
- The consultants and senior nurses were keen to cooperate with the care quality commission inspection process and provided information which was above expectations in a format which was beneficial to the inspection process.
- We noted one area of deference towards consultant doctors in that they had choice of whether to use the printed individual plans of care for the dying patient agreed and ratified by the trust or to confirm

compliance with the five priorities through writing their own plans of care directly into the patient's medical record. This meant there were be two systems in use to promote correct care and support.

Public engagement

- The trust website was well presented and it was easy to find information about end of life care services. The trust actively sought feedback from patients and it was clear that this was valued.
- There were bereavement workshop afternoons offered to relatives and friends. This provided people with an opportunity to discuss the quality of services as well as share their own experiences.
- A patient representative was on the trust's steering group for the Macmillan cancer improvement programme for treating pulmonary cancer in the community.

Staff engagement

- Staff engagement and sharing good practice workshops had been held to discuss the end of life care strategy, to ensure staff were aware and able to contribute to proposed changes.
- There was a link nurse on every ward and clinical area, each had received additional training in end of life care and they were able to influence future training topics and service development.
- Staff we spoke with felt that their views counted and that they were listened to. Some expressed frustration in relation to the lack of succession planning when staff were due to leave the service.
- The trust had not conducted a staff survey aimed at all staff working in palliative or end of life services across directorates and so could not be assured of staff opinion about the current service or future developments.

Innovation, improvement and sustainability

- There had been substantial work and planning undertaken to embed the five priorities of care for the dying person into the trusts services.
- We noted innovative practice which included providing a rolling program of training directly onto each ward; provision of the bereavement information box on each ward; provision of the National end of life qualifications Six Steps Programme to nurses working in nursing homes supported by the trust and introduction of the Family's Voice Diary.
- Improvements and sustainability was promoted through an established culture of responding to changes within the specialism. The service valued research and exchanged ideas and findings with partner agencies from all aspects of palliative care and end of life specialisms including voluntary and education sectors.
- The trust had a staff reward system and individual staff and teams could be nominated for the Diamond award. In November 2015 the bereavement team and manager were nominated for their role in developing the bereavement garden situated outside the bereavement office. It was noted that this was an attractive and tranquil area that relatives could use when they visited the office to collect death certificates or deal with other formalities.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient and diagnostic services are provided by University Hospital of South Manchester NHS foundation Trust at Wythenshawe Hospital. A number of outpatient appointments are also offered at community locations.

The main diagnostic imaging departments at Wythenshawe Hospital are located on the ground floor and are split into two areas. The acute department provides services to the Accident and Emergency department and inpatients and F block provides predominantly outpatient services. Outpatient clinic areas are designated A and B and are on the ground floor and first floor respectively. Wythenshawe hospital is home to the North West Heart Centre and also the Nightingale Centre which is purpose built and provides a clinical service for breast cancer screening and diagnosis. The building includes the Genesis Breast Cancer Prevention Centre for research into prevention, screening and early diagnosis.

Hospital episode statistics data (HES) for July 2014 to June 2015 showed 606,829 outpatient appointments were offered across the trust with 492,552 offered at Wythenshawe Hospital.

Wythenshawe Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities including cardiology, respiratory medicine, breast surgery, gynaecology, dermatology, pain management, trauma and orthopaedics, maxillo-facial surgery, audiology and therapy services.

Wythenshawe Hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI), ultrasound and mammography.

We visited Wythenshawe Hospital between the 26 and 29 January 2016 and inspected a number of outpatient and diagnostic services including audiology, fracture clinic, gynaecology, dermatology, cardiovascular, HIV, breast screening, radiology and diagnostic imaging. We spoke with 12 patients and 45 staff including nursing, medical, allied health professionals, clinical support workers, administration staff and managers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at nine individual care records.

Outpatients and diagnostic imaging

Summary of findings

The trust experienced a shortage of nurses and radiographers within the diagnostic and imaging department.

Ageing equipment within radiology had begun to impact on service delivery and two diagnostic machines were broken during our inspection, however plans were in place to mitigate risk to patients and to maintain and replace equipment.

Log in details of other professionals were used by referrers to radiology. This was reported as a concern and, although this was acknowledged by management, the situation had not been addressed.

Referral to treatment rates were below the national standard between September 2015 and January 2016.

Between June 2015 and September 2015 the proportion of radiological investigations reported on within 10 days ranged from 68% to 75.5%. The did not attend (DNA) rate at Wythenshawe Hospital was higher than the England average each month since February 2015.

There was a clear process for reporting and investigating incidents and we saw evidence of shared learning, however feedback to staff from individual incidents was varied.

Cleanliness and hygiene was of a good standard throughout the areas we visited. Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired. Medication was stored safely in outpatients and radiology departments.

Staff were aware of their role in relation to safeguarding and the trust targets for safeguarding and mandatory training targets were achieved across the outpatients and diagnostic imaging departments.

Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance. Staff worked together in a multi-disciplinary environment to meet patients' needs and information relating to a patient's health and treatment was available from relevant sources before a clinic appointment.

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff and patients we spoke with were positive about the way staff looked after them.

Between September 2015 and January 2016 the number of patients who waited longer than six weeks for non-urgent radiological investigations ranged from 0.8% to 1.7%.

Managers had a good knowledge of performance in their areas of responsibility and understood the risks and challenges to the service and there was an open and honest culture within the service.

Clinical governance meetings were held in radiology and the outpatients directorate to review risks, incidents and complaints. Quality and performance was monitored through the outpatient and radiology dashboard and monthly Divisional Performance reports.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Both managers and staff described challenges with regard to recruitment and retention of nurses and radiographers within the diagnostic and imaging department.

Ageing equipment within radiology had begun to impact on service delivery and two diagnostic machines were broken during our inspection, however plans were in place to mitigate risk to patients and to maintain and replace equipment.

Log in details of other professionals were used by referrers to radiology. This was reported as a concern and, although this was acknowledged by management, the situation had not been addressed.

There was a clear process for reporting and investigating incidents and we saw evidence of shared learning, however feedback to staff from individual incidents was varied.

Cleanliness and hygiene was of a good standard throughout the areas we visited and staff followed good practice in relation to the control and prevention of infection. Equipment was identified as clean by the use of 'I am clean stickers'.

Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.

Medication was stored safely in outpatients and radiology departments. Records we reviewed were of a good standard.

Staff were aware of their role in relation to safeguarding and the trust targets for safeguarding and mandatory training targets were achieved across the outpatients and diagnostic imaging departments.

Staff were aware of their role in the case of a major incident or radiation incident.

Incidents

- There were six serious incidents reported by the trust relating to outpatients and diagnostic imaging between August 2014 and July 2015, one of which was classed as a never event. Never events are very serious, wholly preventable, patient safety incidents that should not occur if the relevant preventative measures have been put in place. All serious incidents were investigated using a root cause analysis approach and of the four we reviewed all documented high level action plans and evidence of shared learning.
- Specific information for Wythenshawe Hospital was not available; however there were 19 recorded radiation incidents across the trust between 20 January 2015 and 28 December 2015. Minutes from Radiation Protection Committee Meetings from June 2015 and January 2016 indicated incidents were reported internally and externally, as required.
- Incidents were reported using an electronic reporting system. Staff were able to demonstrate how they would report an incident; however we were informed by staff that they did not always receive feedback.
- Staff could describe previous incidents and give examples of changes in practice as a result of lessons learned. These included allowing relatives or carers into the x-ray room, where possible, to support patients and changes to the Specimens Handling Policy in the Nightingale Centre.
- Bi-monthly audit meetings were held in radiology attended by all grades of staff to share lessons learned following incidents.
- Staff across outpatients and diagnostics were familiar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and patients and relatives had been informed of incidents which had involved them.

Cleanliness, infection control and hygiene

- All the areas we visited were visibly clean and tidy. Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it.
- We looked at cleaning checklists in diagnostic imaging rooms and these had been completed daily; however evidence in some areas was only available for the week prior to our inspection.

Outpatients and diagnostic imaging

- 'I am clean stickers' were placed on equipment to inform staff at a glance that equipment had been cleaned. We saw evidence of this being used across all departments we visited.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled.
- Staff in radiology could describe the process when patients attended with suspected communicable diseases or requiring isolation including the use of protective equipment and scanning patients at the end of the list, if possible.
- Hand hygiene audits were completed monthly across the outpatient departments and between May and October 2015 three areas scored less than 100% on one or more occasions. In the main outpatients at Wythenshawe Hospital a low score was recorded when doctors only were audited therefore an educational session was held about the five moments of hand hygiene. This is an approach that defines key moments when health care workers should perform hand hygiene.
- The trust performed better than the England average for cleanliness in the patient-led assessments of the care environment (PLACE) audits for 2013, 2014 and 2015.

Environment and equipment

- Managers told us that concern due to the age of interventional radiology equipment was the top risk on the risk register and during our inspection one of the machines had broken down. A risk assessment had been completed and contingency plans were in place to mitigate risk and monitor incidents. We were advised that approval had been obtained to replace equipment in both interventional rooms and the procurement process was ongoing.
- A further piece of radiology equipment had broken in x-ray room six in F block and a part had been awaited since 8 January 2016; however contingency plans had been put in place to ensure continuity of service. We observed no impact to patients from equipment breakdown during our inspection.
- The hospital had two computerised tomography (CT) scanners and one magnetic resonance imaging (MRI) scanner in the acute area, one CT scanner in F block and two MRI scanners in the North West Heart Centre. Local rules were observed in F block and the acute area, signed by staff that used the equipment.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Portable appliance testing (PAT) was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Radiology staff were observed wearing dosimeters to monitor occupational exposure to radiation. This is a device that measures the amount of radiation a person has been exposed to.
- Personal protective equipment was available. This was checked and cleaned weekly and wiped down after use.
- Emergency resuscitation equipment was in place, trolleys we reviewed were visibly clean, well-stocked and checklists completed.

Medicines

- All drugs in outpatients and radiology were found to be in date and medicines were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation.
- Refrigerator temperatures were recorded daily; however this did not include the maximum and minimum range which was against the trust policy. Temperature readings of refrigerators that store medicines and vaccines should be between two and eight degrees and any deviations and corrective action should be recorded.
- No controlled drugs were stored in the outpatient department. Controlled drugs in interventional radiology were checked twice daily and records indicated that this had been missed on two occasions, the afternoon of the 23 December 2015 and the morning of 20 January 2016. Pharmacy support was provided weekly.
- Some specialist's nurses in outpatients were nurse prescribers.
- Prescription pads were stored securely and usage tracked.
- Contrast media was stored appropriately in radiology and processes were in place in nuclear medicine for ordering and handling of radioactive material.

Outpatients and diagnostic imaging

Records

- Availability of medical records for outpatients clinic was audited and data from the trust showed that in August 2015 11.6% of records were not available one day before clinic and in September 2015 11% of records were not available one day before clinic. Staff told us that appointments were not cancelled due to unavailability of records.
- In the Nightingale Centre an electronic copy of the referral letter was available for new patients if records were not received and previous investigation results and letters were available for patients attending a follow up appointment. All new documentation would then be filed in original notes when available.
- We reviewed nine sets of patient records in the outpatients department. Patient identification details were present on all pages within the records; seven had entries that were legible however two sets of notes had entries that were difficult to read. The signature and designation of the health professional was evident in eight records and consent and care plans were present in all records, as appropriate.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Staff described how they had dealt with safeguarding incidents and how advice had been accessed from the safeguarding team.
- The trust target for completion of safeguarding training was 85%. Trust data showed the safeguarding training rate for staff within outpatients clinics was 98% for safeguarding children level one and 91% for level two. Safeguarding training rates for diagnostic staff which included laboratory services, cardiology x-ray, catheter lab, cardiac scanning, the imaging team, general x-ray, ultrasound, MRI scanning, nuclear medicine, electroencephalogram (EEG), electrocardiogram (ECG), breast screeners and interventional radiography was 96% for level one and 85% for level two.
- Training rates for safeguarding adults level one and two was 93% for outpatients and 94% for diagnostic staff.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time. Staff in radiology were observed obtaining name, address and date of birth of patients on arrival which relates to the 'know your patient' initiative as well as a requirement of the Ionising (Medical Exposure) Regulations (IR(ME)R 2000).
- Staff in interventional radiography used the World Health Organisation (WHO) Surgical Safety Checklist. This aims to reduce harm during operative procedures by using consistently applied evidence-based practice and safety checks to all patients. Staff described the process and we observed a completed copy in patient's records.
- Audit of adherence to the WHO Surgical Safety Checklist policy showed that between April and August 2015 radiology achieved 100% compliance; however September and October 2015 rates were 94.8% and 95.8% respectively. In the same period pain clinic achieved 100% compliance each month.

Mandatory training

- Mandatory training was available via on-line courses as well as face to face and included subjects such as infection control, fire safety, equality and diversity and dementia awareness. Locum staff reported receiving mandatory training through their employing agency.
- Some staff told us accessing e-learning had practical difficulties due to work load and IT issues however many took the opportunity to complete this when outpatient clinics were cancelled or working evening or night shifts in radiology.
- The trust target for mandatory training was 85% and data from the trust indicated training rates for staff within outpatients clinics at was 86% and for diagnostic staff the rate was 88%.

Assessing and responding to patient risk

- Staff could identify the Radiation Protection Advisor and details of Medical Physics support were observed on the Radiation Protection notice board within the acute radiology area.
- Radiation Protection Supervisors were appointed throughout the diagnostic and imaging departments and staff reported that regular IR(ME)R updates were provided.
- Staff informed us that there was a list of specified people who could request x-rays; however they experienced challenges when staff from the accident and emergency department completed x-ray requests using the log in of another referrer. This was usually due

to locum staff in the accident and emergency department not having a password and was reported as an incident. Managers acknowledged that when requests were made electronically this could be difficult. Individual doctors were spoken with at the time but stated a higher level approach was required.
- Staff were able to describe the procedure if a patient became unwell in their department including calling the crash team and an ambulance if the patient was in the Nightingale Centre to transfer the patient to the accident and emergency department.

Nursing staffing

- Outpatient clinics were staffed by a combination of specialist and outpatient nurses and the band seven outpatient manager worked across both Wythenshawe and Withington Hospital sites.
- Outpatient nurse staffing was planned in advance to manage the workload; however an outpatient planner was being developed to review clinic utilisation and nurse staffing. This was to allow performance information to inform future planning.
- Data from the trust indicated there was a 14.3% turnover of nursing staff within interventional radiology and managers informed us that this was a challenge to providing an out of hours service; however recruitment was in progress.

Medical staffing

- The radiology department was staffed by consultant radiologists. Trainee radiologists staffed the department on rotation. Trainee radiologists were on a rota to provide 24 hour cover, seven days per week and the duty radiologist was available from 8am to midnight onsite and from midnight to 8am as a non-resident on call. Consultant on call cover was provided 24 hours per day, seven days per week with consultant presence in the department during the day at weekends.
- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants and their medical teams

Allied Health Professionals

- Radiographers provided a 24 hour, seven day service and vacancies and skill mix for radiographers was highlighted as a concern by both staff and managers during our inspection. The total number of radiography staff vacancies was 18.65 whole time equivalents as at 31/01/16 and agency staff were used to cover vacancies.
- Managers described how they were developing job roles internally and also actively out to recruitment for x-ray and ultrasound staff.

Major incident awareness and training

- The trust had a major incident policy which listed key risks that could affect the provision of care and treatment. Staff members were aware of the policy and the role of their department in the case of a major incident.
- Staff in radiology showed us the major incident box and described the actions to be taken in the event of an emergency and staff in nuclear medicine described the process to be taken should a radiation incident occur.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.

Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available in some outpatient areas and advanced practitioner roles had been developed in the Nightingale Centre. Staff were competent to perform their roles; however not all staff reported receiving an appraisal in the last year.

Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment and staff had regional access to previous x-ray images. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.

The radiology and diagnostic service was provided seven days a week.

The rate of follow up appointments in relation to new appointments was higher than the England average between July 2014 and June 2015.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Staff described the use of best practice guidance for lower limb wounds in the outpatients department, the use of NICE guidance for neck of femur injuries in radiology and NICE guidance for diagnosis of Fibroadenoma in the Nightingale Centre.
- Protocols from the Faculty of Pain Management were in use in pain clinic.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and Radiation Protection Committee meetings were held twice a year to monitor radiation safety throughout the trust.
- We observed minutes from Radiation Protection Committee meetings and the action plan for 2015/16 detailing current progress.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part.
- Staff in the ultrasound department took part in external obstetrics audits and also completed internal audits of scans bi-monthly.
- The pathology service had received clinical pathology accreditation (CPA).This involved assessment of all procedures within the laboratory against strict guidelines to ensure a recognised standard of service.
- Audit and staff meetings were held in radiology to share information and promote shared learning.
- The radiology department were involved in national benchmarking and the Nightingale Centre took part in the National Cancer Patient Experience Survey.

Pain relief

- Entonox pain relieving gas was administered in fracture clinic when patients needed it.
- Analgesia could be prescribed for individual patients in outpatients clinic as a single dose prescription using a patient specific direction and local anaesthetic was available to patients undergoing investigation in the Nightingale Centre.

Patient outcomes

- The trust rate of follow up appointments in relation to new appointments was 62% at Wythenshawe Hospital which was higher than the England average of 55% between July 2014 and June 2015.
- Discrepancy meetings were held in radiology. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and therefore improve patient outcomes and safety.
- Double reporting of scans was in place to ensure their accuracy.
- Anonymised complex case reviews took place twice a month in pain clinic to facilitate shared learning.
- The radiology department was involved in national benchmarking. This allowed the service to identify best practice and continuously improve by comparing performance with other similar services.

Competent staff

- Competency assessments were in place in outpatients and radiology for example new staff working in interventional radiology completed training packs including "scrub competency".
- Staff identified their training needs through the trust appraisal process and data from the trust indicated that 86.8% of outpatient staff and 77% of diagnostic staff across the trust had received an appraisal as at November 2015; however staff told us that training opportunities in some areas were limited due to staff numbers.
- Managers described how they managed poor performance including the provision of mentoring and one to one support.
- Staff in outpatients and diagnostic imaging described daily "morning huddles" and monthly staff meetings to promote effective communication.

Multidisciplinary working

- The diagnostic imaging and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- Inpatient "huddles" were held each morning in radiology to ensure patients on the wards requiring investigations were prioritised.
- Specialist nurse led trauma clinics took place every morning in the outpatients department with registrar support.

Outpatients and diagnostic imaging

- The Nightingale Centre had advanced practitioner roles providing radiology and tattooing services. Advanced practitioners are healthcare professionals who have developed expert skills and knowledge in their field.
- One stop clinics were provided in the Nightingale Centre so that, following consultation and examination, patients could undergo investigation such as mammogram, ultrasound and aspiration according to clinical need and receive results within the same visit. This ensured patients received prompt results which helped to reduce anxiety and also prevented the need for patients to return for several appointments.
- Staff in the Nightingale Centre worked from a central hub where patient flow was managed and this also allowed for multi-disciplinary discussions between radiologists, radiographers, nurses and surgeons.
- Letters were sent from the outpatients department to patient's GPs to provide a summary of the consultation and radiology results were sent electronically or faxed.

Seven-day services

- The diagnostic and imaging departments provided services such as blood tests, x-ray and scanning at the weekend and interventional radiography was available as an on call service.
- Radiology reception was available for 12 hours per day including Saturday and Sunday.
- There were no regular outpatient clinics offered at weekends but additional clinics were scheduled on occasion. At the time of our inspection additional pre-operative clinics were being held to meet demand.

Access to information

- The radiology department used a nationally recognised system to report and store patient images. The system was used across the trust and allowed local and regional access to images.
- Previous images could be viewed by staff and some GP's were linked to the IT system allowing for prompt access to images.
- Staff were able to access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent.
- If written consent was required for more complex procedures this was obtained in outpatients clinic by medical staff.
- Staff in the Nightingale Centre advised that that they had recently been involved in a best interest meeting for a patient. A best interest meeting is held if an adult lacks the mental capacity to make specific decisions for themselves and needs others to make those decisions for them.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful.

The patients we spoke with were positive about the way staff looked after them. Care was planned that took account of patients' needs and wishes.

The trust had a number of clinical nurse specialists available for patients and their families to talk to about their condition.

Compassionate care

- Patients and relatives told us that staff were caring and friendly. We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.
- The main outpatient booking in area operated a queuing system which allowed patients to speak with the receptionist without being heard.
- Staff described how difficult messages were given to patients in the Nightingale Centre and that a specialist breast care nurse would be present for the consultation.
- We spoke with patients and families who told us they couldn't praise the care too highly, how it was "a very positive experience" and "nothing needs to improve".
- The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family, showed 97% of patients would recommend outpatients services to family and friends.

Outpatients and diagnostic imaging

- NHS Friends and Family forms and response feedback were displayed in the reception of the Nightingale Centre to inform patients.

Understanding and involvement of patients and those close to them

- We spoke with a 17 year old with their mother who told us everything was explained well and that medical staff had directed questions to the young person.
- We observed staff explaining the procedure to an elderly lady attending for a mammogram with kindness and respect.
- Patients were informed following diagnostic investigations when they should contact their GP for the results.

Emotional support

- The trust had a number of clinical nurse specialists available for patients to talk to about their condition.
- A keyworker was allocated to every patient following a cancer diagnosis in the Nightingale Centre and involvement was not time limited. A sunflower pack was also provided which included breast cancer care information and patients were signposted to the Macmillan information centre on the hospital site.
- Patients considering breast reconstruction following a cancer diagnosis were provided with a separate appointment to talk through the process with specialist nurses in a more relaxed environment.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Referral to treatment times across the trust for patients awaiting outpatient care were below the national standard between September 2015 and January 2016.

Between June 2015 and September 2015 the proportion of radiological investigations reported on within 10 days ranged from 68% to 75.5%.

The did not attend (DNA) rate at Wythenshawe Hospital was higher than the England average each month since February 2015.

The reception areas in acute radiology and fracture clinic were very open and patients' conversations could be heard as they booked in.

Between September 2015 and January 2016 the number of patients who waited longer than six weeks for non-urgent radiological investigations ranged from 0.8% to 1.7%.

Additional pre-operative clinics were held at weekends to reduce waiting times for patients and telemedicine clinics were available in maxillofacial clinic.

Divisional performance data reviewed indicated that 100% of complaints were responded to within the time-frame agreed with the complainant in November 2015.

Service planning and delivery to meet the needs of local people

- We observed clear signposting through the hospital to the outpatients and diagnostic imaging departments.
- Waiting areas with sufficient seating were available with access to toilets and drinking water.
- Patients attending outpatients A and B and F block x-ray could access the shop located nearby and a vending machine was located in the reception area of acute x-ray.
- Patients we spoke with during our inspection raised consistent issues associated with the availability and cost of parking at the hospital.
- Additional pre-operative clinics were held at weekends to reduce waiting times for patients and telemedicine clinics were available in maxillofacial clinic.
- A self-check in facility was in use the outpatient reception to improve patient flow; however staff told us this was not always working. An audit of use completed over two weeks in May and June 2015 revealed that 24% of respondents did not use the service because either the screens were not on or they could not find them.
- The reception area in the Nightingale Centre had signs asking patients to respect patient confidentiality and wait to be called forward; however, the reception areas in acute radiology and fracture clinic were very open and patients' conversations could be heard as they booked in.
- Signs were observed on consultation room doors in outpatients clinic A and B advising that clinical tests were in progress and to remind staff to "think privacy and dignity".

Outpatients and diagnostic imaging

- Pagers had been trialled in the outpatient department prior to our inspection to enable patients to leave the waiting area and be recalled when it was time for their consultation however they were no longer in use. Staff reported this had been a positive service development however no formal audit was carried out.
- Volunteers were present in the main reception area to assist patients with the self-check in process and provide directions.

Access and flow

- Referral to treatment rates for incomplete pathways were better than the national standard and the England average each month between September 2014 and July 2015, but fell below the standard and average between September 2015 and January 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- The percentage of people seen by a specialist within two weeks of urgent GP referral was better than the England average every quarter between quarter two 2013/14 and quarter one 2015/16.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was better than the England average every quarter between quarter four 2013/14 and quarter one 2015/16.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average every quarter between quarter three 2013/14 and quarter one 2015/16.
- Between July 2015 and October 2015 clinics cancelled within six weeks of the date ranged from 3.46% to 4.18%, the main reasons being due to annual leave, study leave and sickness. The number of clinics cancelled over six weeks from the date ranged from 9.59% to 12.57% for the same period.
- The national standard for non-urgent radiological investigations is less than 1% of patients wait more than six weeks. Between September 2015 and January 2016 the trust ranged from 0.8% to 1.7%.
- Between June 2015 and September 2015 the proportion of radiological investigations reported on within 10 days ranged from 68% to 75.5%.
- The trust had a number of patients who failed to attend for their appointments. The did not attend rate at Wythenshawe Hospital was 7%, this was higher than the England average each month since February 2015.

Meeting people's individual needs

- Patients told us they received instructions with their appointment letters and were given written information, as needed. However two of the three patients we spoke with who were attending follow up appointments advised that they had not received copies of clinic letters from previous consultations.
- Information boards were observed in outpatients clinic and the Nightingale Centre advising patients of the medical and nursing staff on duty that day as well as current clinic waiting times.
- Staff described how people in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required.
- Access to interpreting services could be arranged by telephone for those patients who did not speak English. If staff were alerted to a patient's requirements, translators could be booked in advance; however we did not see this system in use as we did not observe any patients requiring translation services during our inspection. The self-check in facility prompted patients to choose which language they wanted to use for the process.
- Facilities for bariatric patients were observed in outpatients clinic B; however the trust had identified some issues in the Nightingale Centre.
- Staff described how they had provided patients with a private area to wait in or escalated their appointment if they saw a patient becoming distressed or anxious and male patients attending the Nightingale Centre could be accommodated in an alternate waiting room if they wished.
- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available.

Learning from complaints and concerns

- Initial complaints were dealt with by clinic managers in the outpatients department in an attempt to resolve issues locally; however if this was unsuccessful information was provided about the patient advocacy and liaison service (PALS).

Outpatients and diagnostic imaging

- Staff we spoke with knew how to signpost patients to the PALS department and we observed green comment cards available for patients to complete in the departments we visited.
- Divisional performance data reviewed indicated that 100% of complaints were responded to within the time-frame agreed with the complainant in November 2015.
- The trust had a complaints policy and we reviewed 42 complaints received by the trust relating to outpatients and diagnostics at Wythenshawe Hospital in 2015. Of the complaints reviewed 21 referred to communication and attitude of staff.

Are outpatient and diagnostic imaging services well-led?

Good

Managers had a good knowledge of performance in their areas of responsibility and understood the risks and challenges to the service.

Directorate and clinical leads were visible and approachable. Clinical governance meetings were held in radiology and the outpatients directorate to review risks, incidents and complaints. Quality and performance was monitored through the outpatient and radiology dashboard and monthly Divisional Performance reports.

There was an open and honest culture within the service and good team working was observed. Staff were positive about the contribution of colleagues in areas with staff shortages.

Patients' views were actively sought and there was evidence of continuous improvement and innovation.

Not all staff were aware of the trust vision.

Vision and strategy for this service

- The trust vision was "to be a top 10 NHS provider in the country" and the outpatients and diagnostics local strategy plan –"the quality diamond" was aligned to this. We observed this displayed on notice boards around the hospital.
- The hospital had recently undergone a change to the organisational structure and while some staff reported an awareness of the trust vision, some were unsure.
- Outpatients and diagnostics were led by directorate managers and a number of department specific clinical leads. Staff told us that directorate and clinical leads were visible and approachable.

Governance, risk management and quality measurement

- Managers completed a walk round of every area in radiology each morning to identify any emerging risks to service delivery.
- Clinical governance meetings were held in radiology and the outpatients directorate to review risks, incidents and complaints.
- Radiation safety committee meetings were held twice a year to ensure that clinical radiation procedures and supporting activities in the trust were undertaken in compliance with ionising and non-ionising radiation legislation.
- The radiology and outpatients department recorded risks on the departmental risk register. We found that risks identified during our inspection were on the risk register with action plans and progress notes, for example concerns regarding dose levels due to the age of the interventional radiology equipment.
- Quality and performance were monitored through the outpatient and radiology dashboard and monthly divisional performance reports. These covered data such as referral to treatment times and radiology turnaround times as well as outpatient clinic utilisation, staff sickness rates, infection rates, incidents and complaints.

Leadership of service

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Staff felt supported by their local managers but said the executive team were not visible.
- Monthly team meetings took place in outpatients and radiology and some staff reported receiving trust communication by email.

Culture within the service

- There was an open and honest culture within the service and staff were candid about the challenges they faced.

Outpatients and diagnostic imaging

- Managers and staff told us that staff shortages had impacted on morale; however we observed good team working.
- Staff were positive about how hard colleagues had worked in areas that had vacancies.

Public engagement

- Additional local surveys were conducted within outpatients and radiology to obtain more detailed feedback from patients and inform service development such as the "5 Days No Delays" held 19 – 23 October 2015 in area seven, ear, nose and throat (ENT). As a result a series of next steps was identified including a review and standardisation of clinic boards and reception desks.
- A patient satisfaction audit was also completed in the Nightingale Centre and comments cards and post boxes were visible in areas we visited such as at the entrance to the acute x-ray department and fracture clinic.
- The Nightingale Centre was involved in the National Cancer Patient Experience Survey.

Staff engagement

- The outpatient department had introduced an outpatient forum with representation from each directorate. The aim of the group was to share good practice and learn about the current issues for outpatient services across the organisation with a view to improving services. This also included contributions from partner agencies.
- Results of the 2015 NHS Staff Survey showed the trust scored higher than the national average for acute trusts for effective team working and 91% of staff agreed their role made a difference to patients and service users.

Innovation, improvement and sustainability

- A "5 days no delays" initiative had taken place in outpatients department to improve service delivery and achieve a "perfect week".
- The Nightingale Centre was a leading recruiter for breast cancer research in the country and was home to the Genesis Prevention Centre.
- The Genesis Family History clinic provided genetic counselling to patients with high-risk genetic factors.

Outstanding practice and areas for improvement

Outstanding practice

- The bereavement midwife had been nominated for the national Butterfly awards two years running. These are awards celebrating survivors and champions of baby loss. The bereavement midwife was also runner up in the Royal College of Midwifery awards for her work providing bereavement support.
- A rapid access clinic had been introduced for menstrual disorders and post-menopausal bleeding to meet demand and allow for the development of innovative out-patient treatments such microwave endometrial ablation and hysteroscopy sterilisation.
- The cystic fibrosis team were awarded the quality improvement award by UK cystic fibrosis registry annual meeting in July 2015. The paediatric CF team won the first National Cystic Fibrosis Registry Quality Improvement Award in recognition for innovative use of the Port CF database, which provided focussed and early intervention to prevent further deterioration in their patient's condition.

Areas for improvement

Action the hospital MUST take to improve

In Medicine:

- The trust must ensure that staffing levels are appropriate to meet the needs of patients across the medical services and ensure there is an appropriate skill mix on each shift.
- The trust must ensure that all records are stored securely when not in use.
- The trust must take action to improve the bed occupancy rates across medical services to ensure the safe care and treatment of patients.

In Maternity:

- The trust must improve mandatory training for midwifery staff in terms of safeguarding level three training to ensure it is in line with the trust target.
- The trust must ensure all clinical policies are regularly reviewed and kept up to date.
- The trust must ensure incidents are investigated in a timely manner to ensure lessons are learned and recommendations implemented.

In Children and Young People:

- The service must ensure safe staffing levels are sustained in accordance with National professional standards and guidance.
- The service must ensure that staff are reporting risks and incidents to the senior leaders of the service actions being taken in a timely manner.
- The service must ensure that all treatment, assessments, diagnostics and any other care relating to the patient is recorded appropriately in patient records.
- Ensure that transition arrangements for children between 16 and 18 years meet the needs of the individuals without prejudice.

Action the hospital SHOULD take to improve

In the Emergency Department:

- Consider introducing a way of recording completed cleaning by domestic staff in the ED.
- Review the security of the paediatric ED entrance.
- Review the checklists for equipment in the resuscitation area with a view to ensuring clarity about action to replace items.
- Review the storage of equipment in open packaging, or without packaging in the resuscitation area.
- Review how staff record temperature ranges for fridges containing medicines requiring storage at low temperature, to ensure information is properly captured and available for analysis if required.

Outstanding practice and areas for improvement

- Review the benefit of covering vents in the ceiling of the room used for mental health patients to ensure the reduction in ligature risk.
- Improve the uptake of mandatory training for medical and nursing staff.
- Review ways to reduce locum usage in the ED whilst maintaining appropriate staffing levels.
- Improve service for patients and relatives in relation to offering food and refreshments in the ED.
- Put appropriate actions in place to improve services following local or national audit and that relevant staff are aware of findings.
- Improve staff appraisal rates.
- Review the role of the discharge lounge in ensuring access and flow through the ED.
- Review the level of risk to ED reception staff and if required take further steps to mitigate this.

In Medicine:

- The trust should take action to ensure that all necessary patient risk assessments are completed across medical services in accordance with the National Institute for Health Care Excellence (NICE) guidance.
- The trust should ensure that all ligature risks are identified and risks mitigated to ensure patients at risk of harming themselves are protected.
- The trust should ensure that patients are discharged as soon as they are medically fit.
- The trust should ensure that patients are not moved ward more than necessary during their admission and are cared for on a ward suited to their needs.
- The trust should take action to ensure that all staff receive annual appraisals.
- The trust should take action to provide the necessary mandatory training for medical staff.
- The trust should cascade major incident planning information to all staff across medical services.
- The trust should take action to ensure audit data is submitted to the advancing quality programme.

In Critical Care:

- Take appropriate actions to reduce the number of delayed discharges.
- Take actions to ensure patients kept in theatre recovery receive appropriate care and treatment.

In End of Life:

- The trust should ensure that all staff groups have access and are trained to use the trusts electronic reporting system.
- The trust should consider requesting feedback about the quality of mortuary services from partner agencies such as funeral directors.
- The trust should consider developing a work schedule in relation to narrowing the gap between preferences and place of death.
- The trust should set targets for completing all action plans.
- The trust should consider making testing major incident plans.
- The trust should consider ensuring audits reach the appropriate target audience so that senior clinicians are able to comment on their area of responsibility such as use of the individual plan of care booklet.
- The provider should ensure all doctors who sign DNACPR include their position and GMC number as requested on the form.
- The trust should ensure the leadership structure for all services involved in palliative and end of life care is clearly defined.
- The trust should consider completing a staff survey to enable staff to comment on the quality of the service and future developments.
- The trust should consider making the use of the most effective end of life care planning tool mandatory or develop a policy and risk assessment which supports two systems currently in use.

In Outpatients and Diagnostic Imaging:

- The trust should take action to ensure that equipment is available and fit for use with minimal disruption to the service.

Outstanding practice and areas for improvement

- The trust should ensure a record is maintained of the minimum and maximum of fridge temperatures for each medication fridge.
- The trust should take action to address the issue of x-ray requests being completed using the log in of another referrer.
- The trust should put measures in place to allow patients to book in to outpatient and diagnostic areas without being overheard.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not always secure. This was because record trolleys were left unlocked on medical wards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** We found significant delays in investigating and reviewing incidents within midwifery and subsequently lessons learned were not being identified in a timely manner and recommendations not implemented to prevent further incidence from occurring. In addition we found significant delay in updating clinical guidance with many being out of date. Regulation 17(2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet peoples care and treatment needs.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes must enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes must enable the provider to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Care and treatment for service users must not be provided in a way that significantly disregards the needs of the service user for care or treatment.**

Regulated activity	Regulation
Nursing care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15(1)(e)(f): All equipment used by the service provider must be properly maintained**

This section is primarily information for the provider

Requirement notices

Records in the ED showed that equipment checks which should have been completed daily in the resuscitation area were not completed on nine dates out of 27 in January 2016.

Records in the ED were lacking in relation to daily checks of fridges storing medicine at low temperature.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a): Persons employed by the service provider must receive such appropriate appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff appraisal rates in the ED did not always meet the trust target.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(b): Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. ED reception staff worked behind open desks accessible to the public. An incident had already occurred whereby a member of the public entered the reception area. We saw vents in a room assigned for mental health patients in the ED which we were concerned could be a potential ligature risk.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Nursing care

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(a): Providers must monitor progress against plans to improve the quality and safety of services and take appropriate action with delay where progress is not achieved as expected.

The trust consistently failed to achieve standards in line with Department of Health targets for EDs such as but not limited to the target to admit, treat or discharge patients within four hours.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

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