Salford Royal NHS Foundation Trust

Quality Report

Salford Royal Hospital
Stott Lane
Salford
Greater Manchester
M6 8HD
Tel: 0161 789 7373
Website: www.srft.nhs.uk

Date of inspection visit: 13, 14, 15 and 27 January 2015
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this trust. 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 trust	Outstanding ☆
Are services at this trust safe?	Good ●
Are services at this trust effective?	Good ●
Are services at this trust caring?	Outstanding ☆
Are services at this trust responsive?	Outstanding ☆
Are services at this trust well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Salford Royal NHS Foundation Trust provides both acute and community services to a population of 240,000 people across Salford and the surrounding areas of Greater Manchester. The trust serves a national population for those requiring some specialist care for the treatment of disease or disorders of the brain, skin, renal system, spine and those with intestinal failure conditions.

Salford Royal NHS Foundation Trust employs around 6,600 whole time equivalent staff across both the acute hospital and community services. Of these staff there are 730 medical staff, 2,200 nursing staff, 2,000 care support staff and 350 allied healthcare professionals.

We carried out this follow-up inspection in addition to our comprehensive inspection which we undertook in October 2013, as Salford Royal Hospital was inspected during a pilot period when shadow ratings were not published. In order to publish a rating we needed to update our evidence and inspect all of the core services that are provided by Salford Royal Hospital. In addition, we had not inspected the community services provided by the trust during our inspection in 2013. Our methodology included an unannounced visit carried out on the evening of 27 January 2015 and a public listening event. At the public listening event we heard directly from approximately 60 people about their experiences of care.

We have rated the trust overall as outstanding. The Salford Royal Hospital was rated as outstanding and the community services as good. On CQC's five key questions safe and effective were rated as good, while caring responsive and well led were judged to be outstanding at trust level. In relation to core services, A&E, medicine and end of life care in the acute hospital and adult services and end of life care in the community were each rated as outstanding..

Throughout this trusts reports, reference will be made to the Nursing Assessment and Accreditation System (NAAS) and the trust wide initiative to provide safe, clean and personal care every time (SCAPE).. The Nursing Assessment and Accreditation System (NAAS) is a performance framework system designed to help nurses in practice by measuring the quality of nursing care delivered by teams. This performance assessment framework is based on the Trust's Safe, Clean, Personal approach to service delivery and combines Key Performance Indicators and Essence of Care standards. The framework is designed around 13 standards with each standard subdivided into three elements: leadership, care and environment. The assessment consists of observations of care, asking patients and staff relevant questions, observing meal delivery, and receiving patient feedback. Wards and departments are rated from red (worst) to blue (SCAPE – best). Where we have reported that wards have attained SCAPE status, this indicates that the ward has been assessed over a period of at least 24 months, and during each assessment, had attained at least a green rating (good). Three consecutive green assessments result in SCAPE status being awarded.

For a ward to achieve SCAPE status they must, as a minimum, have maintained NAAS (green) for 24 months. Further assessments are undertaken using a comprehensive set of standards for nursing care and the teams can then apply for SCAPE. A SCAPE panel (consists of board members, senior multi-professional staff and a member of the public) then reviews the teams and makes recommendations to trust board that will approve, defer or decline SCAPE status for the applying area.

Leadership of the Salford Royal Hospital was rated as good overall with three core services that each demonstrated outstanding leadership; two core services that were rated as good and two core services that required some improvements to be made. The community leadership was rated as outstanding overall; trust-wide leadership was evident to be outstanding. The aggregation of these judgements for assessing well-led at provider level is outstanding overall. Combining the overall ratings of outstanding for caring, responsive and being well-led results in the overall trust being rated as outstanding.

Our key findings were as follows:

Safe:

- The concept of providing safe, harm free care was considered as a priority by all members of staff.

Summary of findings

Through the use of quality improvement programmes, we found many examples of how staff had worked together to ensure they provided safe care.

- The use of internal governance systems to ensure that safe care was being provided was well embedded. Nursing assessment and accreditation systems (NAAS) provided the trust board and patients a high level of transparency in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. The accolade of SCAPE was seen as significant success by clinical leaders and ward based staff.
- The hospital was visibly clean and staff were witnessed to follow appropriate infection control practices. Audits were routinely undertaken to ensure staff complied with local and national policies and action was taken if areas of concern were identified.

Effective:

- Staff based cared on best practice guidance. A robust audit programme was in place to demonstrate that where improvements were required, action was taken and outcomes monitored to determine effectiveness. The trust benchmarked itself against a range of national comparators; this demonstrated that the trust generally performed the same as, or better than others in many areas.
- Multidisciplinary working was strongly embedded across the trust. The provision of integrated care through the development of Salford Health Care was demonstrable of the abilities of the trust to provide care through multidisciplinary working.

Caring:

- There was a strong emphasis on providing caring, compassionate and dignified care to patients. Performance against national patient satisfaction surveys was consistently good across of all core services with the exception of children and young people's services where further work was required to seek the feedback from children and their parents/ carers.
- People who used the services were actively involved in developing improvements in their care to ensure the care they received was personal. In January 2013 the trust launched a project aimed at improving patient, family and carer experience as part of the patient experience strategy.This resulted in the concept of 'always events', which were things that patients should always expect to happen to them when in receiving care from the trust

Responsive:

- Services were able to assess and respond to the needs of the population they served. Feedback was sought from patients and relevant stakeholders to enhance services.
- Provision of religious and spiritual support and the support of patients during the end stages of life was noted as being particularly outstanding.
- The critical care department provide a combination of ward, telephone and outpatient multidisciplinary follow up service.They contributed to the development of NICE guidelines (2009) on critical care rehabilitation. They proactively gather feedback on the service for evaluation.
- The hospital had a multi-faith centre which catered to the religious needs of the local population including a non-denominational 'Oasis' room.
- A blue butterfly symbol was introduced within the trust to identify service users with cognitive impairment. Patients identified as such, were visited by dementia specialist nurses who also co-ordinated training for staff members on dementia awareness. All wards had a dementia champion.
- Patient passports were in use across the trust, including passports in different languages.

Summary of findings

- The trust had a rigorous complaints answering process to address both formal and informal complaints. Each department had a lead nurse in charge of reviewing and acting on complaints and disseminating the learning from the complaints through safety huddles and newsletters.

Well-led:

- Quality improvement was a clear focus for the trust through collaboration across all staff groups in quality improvement methods to reduce patient harm, improve outcomes and patient experience.One 'collaborative' focussed on gathering patient views across the whole pathway of care from prior to admission to the community to make improvements
- Members of the senior management team were fully engaged with 'front-line' staff. Strong working relationships had been developed between the trust executive team and the Foundation Trust Governors. Governors were clear about their roles and purpose which enabled them to contribute to the success of the trust.
- The ambition and vision of the trust to be the safest trust in the National Health Service was understood and embedded in the practices of staff across all professions and at all levels of seniority.
- Staff spoke positively about the engagement of the management team which enhanced a culture of innovation; high staff satisfaction rates were representative of the positive feedback we received from staff during the inspection.
- The trust had a clear vision and strategy for quality improvement within the trust and for working with partners across Wigan, Bolton and Salford and more widely.
- The trust has some of the best scores in the country on the staff survey, reflecting the positive culture in the organisation.

We saw several areas of outstanding practice including:

- Nursing assessment and accreditation systems (NAAS) provided the trust board and patients a high level of transparency in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider and scrutinise.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. The accolade of SCAPE was seen as significant success by clinical leaders and ward based staff.
- There was clear evidence that the development of the 'emergency village' with its integrated care pathway approach, including medical in-reach, continued to deliver improved outcomes for people.
- Quality improvement initiatives had successfully led to a reduction in the number of hospital acquired pressure ulcers.
- Staff were encouraged to undertake research, for example, we reviewed a paper published in respect to improving patient care in a national intestinal failure unit.
- The surgical division celebrated the positive arrangement they had for the movement of elective orthopaedic work off site and anticipated this would improve patient throughput, standardise use of prosthetics and develop a centre of excellence.
- The surgical division indicated they had established a link with Central Manchester NHS Foundation Trust, which they anticipated could lead to future partnership working in their developed Manchester Orthopaedic Centre.This was expected to lead to increased pooled volumes of specialist activity with standardised practice leading to improved patient outcomes.
- The surgical division annual plan described the development of a service model for emergency and complex surgery with two other NHS providers.
- We saw in the theatre staff newsletter produced for December 2014 an introduction to the forthcoming 'Theatre Improvement Programme'. We were told

Summary of findings

this was due to commence at the end of January 2015, with the aim of ensuring theatres could provide safe and reliable care, provide value and efficiency and deliver a high team performance with high team morale and well-being.This work was being co-ordinated and delivered through a Quality Improvement methodology, led by a steering group headed by the Director of Organisational Development and Corporate Affairs. We saw from information provided to us that the programme was based around the Productive Operating Theatre model, developed by the NHS Institute for Innovation and Improvement.

- The senior managers within the surgical directorate recognised the areas for further focus, which included interventional radiology, middle grade recruitment to medical staff, the delivery of complex emergency care and making improvements to the discharge process, by reviewing and enhancing the patient pathway.
- There was an incentive for staff who wished to be involved in helping the trust to make financial savings to the service. If an idea was adopted, the staff member received 10% of the overall savings as a reward for their innovation.
- Rotating junior staff to other areas across the critical and high dependency care units to facilitate personal progression and encourage staff retention.
- Bleeps were provided to relatives in order that they could be contacted quickly by staff if they were away from the CCU.
- The diabetes outpatient service demonstrated good practice where children in transition from young people to adulthood were seen in a clinic attended by an adult physician and adult specialist nurses, giving dietetic and psychological support. This ensured a continuous and consistent pathway of care through to adulthood.
- We were told the trust was actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. The Trust had pilotedthe use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB) which were used to support patients that are assessed as acutely unwell deteriorating, with limited reversibility and where recovery is uncertain however it was decided not to continue to implement the ACB after the pilot.
- Other improvement areas include Advance Care Planning (ACP), EPaCCS, rapid discharge pathway, meeting the priorities for care of the dying person and effective care after death including bereavement and mortuary service.
- Innovative work undertaken included the access to seven day Specialist Palliative Care for SRFT since 2009 (only 21% of trusts deliver this nationally). The trust has participated in all 4 rounds of the NCDAH and the trust was described as above the national average for 9 out of 10 Clinical KPI's. The bereavement care delivered across the trust and the trusts awareness around cultural needs of the population were well met by the HSPC, bereavement and the chaplaincy teams.
- The system of daily safety huddles, and intra-team situation reports ensured that important information was passed between teams and shifts.
- The team-based audit programme and the monitoring of results and actions.
- The Community Assessment and Accreditation System, and arrangements for gathering patient feedback.
- The mandatory training and professional registration monitoring systems.
- The system of competency assessment and associated records.
- The use of the "Butterfly Scheme" for people living with dementia.
- The arrangements for ensuring the safety and security of lone workers in community adult services.
- The Care Home Medical Practice was a beacon of innovation and excellence, reducing unplanned hospital admissions and supporting people to remain in their preferred place of care until their death.

Summary of findings

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

Action the hospital MUST take to improve

- The trust must take action to ensure that WHO safety checks (or equivalent) are conducted on all patients going through operating theatres and must take action to ensure that monitoring of WHO safety checks are carried out.
- The trust must ensure that the environment is appropriately maintained and fit for purpose; the main out-patient department experienced a regular leaking roof in several areas, and sewage leaks through the ceiling.

Summary of findings

Action the hospital SHOULD take to improve

- The trust should ensure that safety checks on technical equipment used in the delivery of treatment and care to patients is carried out routinely. This is something that is required as part of Regulation 16, safety, availability and suitability of equipment. It was considered that the omissions related to the checking of anaesthetic machines by theatre staff was not proportionate to support a judgement of a breach of the regulation.
- The trust should ensure that the knowledge and application of the Mental Capacity Act and the Deprivation of Liberty Safeguards is consistently applied across all services.
- The trust should ensure that it makes consideration of improving the discharge process to patients from the wider geographical area, beyond the local service area.
- Whilst we acknowledge that the Trust has embarked on a programme of quality improvement within theatres to improve the culture and morale, the trust should ensure that this initiative is both effective and sustainable so that changes are fully embedded for the future.
- The trust should consider ways of reducing the rate of surgical procedure cancellations.
- The trust should consider a unified strategy for the delivery of children's services, both medical and surgical; governance systems, risk management and performance measurement processes should be standardised to ensure children receive quality, evidence based care.
- The provider should consider arrangements for the management of patient records at Walkden Gateway.
- The provider should consider how discharge information between the acute and community sectors could be made more effective.
- The provider should ensure that patient records at Swinton Hall are appropriately secured and kept safe.
- The provider should review its current storage arrangements at Heartly Green to ensure equipment is stored appropriately and safely.
- The provider should review existing arrangements with regards to the supply of medicines at Heartly Green to ensure medicines are made available without unnecessary delay.
- The provider should ensure that all Control Drug log books are maintained in line with national requirements.
- The trust should review existing pathways to ensure that children who were not in mainstream education were appropriately identified in order that their health and development needs can be identified and assessed in line with national programmes.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Salford Royal NHS Foundation Trust

The trust is an NHS Foundation Trust that is an integrated provider of hospital, community and primary care services.

The trust revenue is £449 million and until this financial year had shown a surplus; the trust currently has a small deficit.

At the time of the inspection there was a stable executive team. The CEO had been in post for twelve years and the Executive Nurse Director/Deputy CEO joined Salford Royal Hospital in 2004.

The Chair was appointed as a Non-Executive Director at Salford Royal NHS Foundation Trust in November 1999. He was appointed as Chairman on 1 July 2008.

Salford Royal Hospital has 839 beds of which 38 are designated critical care beds. Services for children do not include inpatient beds although there is a Paediatric Assessment and Decision Area (PANDA) unit attached to the accident and emergency department. Some children's day surgery is carried out at the hospital.

Salford District is ranked 26 out of 326 local authorities in the Indices of Multiple Deprivation putting it well below the England and regional averages for indicators such as life expectancy.

We carried out this follow up inspection in addition to our comprehensive inspection in November 2013, as Salford Royal Hospital was inspected during a pilot period when shadow ratings were not published. In order to publish a rating we needed to update our evidence and inspect all core services and 'well-led' trust-wide.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission.

Head of Inspection: Heidi Smoult, Deputy Chief Inspector of Hospitals, Care Quality Commission

The team of 54 included CQC inspectors and managers and a variety of specialists including doctors, registered nurses, a student nurse, therapists, experts by experience and senior NHS managers.

How we carried out this inspection

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

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

The inspection team inspected the following seven core services that are provided by Salford Royal Hospital:

- Accident and emergency services
- Medicine (including care of older people)
- Critical care
- Services for children and young people
- End of life care services
- Adult Services
- Inpatient services
- Children's services
- End of life care

Summary of findings

Prior to this inspection we reviewed a range of information we held about the trust. We reviewed the information from organisations that had shared what they knew about the trust with us prior to the inspection in October 2013. These include the Clinical Commissioning Groups (CCGs) that contracted with the trust, NHS England, Health Education England (HEE), The General Medical Council (GMC), The Nursing and Midwifery Council (NMC), the Royal Colleges and Healthwatch. We liaised with a proportion of these stakeholder organisations prior to this follow up inspection.

We interviewed staff and managers, talked with patients and staff from wards and departments across the hospital and also with carers and family members of patients. We observed how people were being cared for and reviewed patients' records of personal care and treatment. We also reviewed information supplied to us by the trust and reviewed data that CQC holds on the trust.

What people who use the trust's services say

In the Adult Inpatient Survey in 2013 Salford Royal Hospital NHS Foundation Trust scored 'better' in six of 10 questions. Of the individual 60 questions asked the trust performed better than other trusts in twenty questions.

The results of the 2013 NHS Staff Survey demonstrated that Salford Royal hospital performance was better than expected in 23 of the indicators and placed within the top 20% of trusts nationally, while none of the indicators were within the bottom 20% of trusts nationally.

Friends and Family Test results showed the average scores for both inpatients and A&E were better than the national figure for 2012/13. In addition, the response rate for both inpatient and A&E for April to June 2014 was better than the national percentage.

The Cancer Patient Experience Survey (CPES), Department of Health, 2013/2014, showed that out of 69 questions, for which the trust had a sufficient number of survey respondents on which to base findings Salford Royal hospital was rated by patients in the top 20% of all trusts nationally for 26 of the 69 questions.

Facts and data about this trust

Context

- Foundation Trust since 2006
- Around 839 beds
- Serves a population of around 240,000
- Employs around 6,600 whole time equivalent members of staff

Activity

- Inpatient admissions 47,461(excluding day and regular day/nights) between October 2013 and September 2014.
- Total outpatient attendances 397,029 between October 2013 and September 2014
- A&E attendances 92,176 between October 2013 and September 2014

Intelligent Monitoring –

Score	Items	Risk	Elevated	
Safe	8	0	0	0
Effective	31	0	0	0
Caring	21	0	0	0
Responsive	10	1	0	1
Well led	24	0	1	2
Total	94	1	1	3

The risk in responsive is for referral to treatment (1 July 2014 to the 22nd July 2014)

The elevated risk in well led is for whistle blowing alerts (18 July 13 to 29th September 14)

Summary of findings

Key Intelligence Indicators

Safety

One never event in last 12 months – In community wrong site surgery (extraction of incorrect tooth)

- STEIS 18 Serious Untoward Incidents (April 2013 - May 2014)

Infections

- C-difficile within expectation
- MRSA one case in September 2014

Effective

- HSMR - 84.8 Better than expected April 2013 March 2014
- SHMI - 94.4 Similar to expected April 2013 March 2014

Caring

Friends and Family Test

- Average score for both inpatients and A&E are similar to the national average for 2013/14
- Response rates for both inpatients and A&E are better than the national average for 2013/14

Cancer Patient Experience

- In the top 20% of all trusts nationally for 26 of the 69 questions

CQC Adult Inpatient Survey

- Trust scored 'better performing trusts' for six out of 10 questions and about the same as other trusts for all other questions.

Responsive

A+E 4 hour target

- Inconsistently met the 95% in the previous 12 months

Referral to treatment

- Did not consistently met the admitted and non-admitted pathways

Cancer 2 week wait

- Consistently met the national target

Cancer 31 day wait

- Did not consistently met the national target

Cancer 62 day wait

- Did not consistently met the national target

Well-led

Staff survey 2013:

- In the top 20% for 23 of the 30 questions with 0 questions in the lowest 20%
- 86% of staff feeling satisfied with the quality of work and patient care they are able to deliver (better than average)
- 92% of staff agreeing that their role makes a difference to patients (better than average)
- 84% of staff having equality and diversity training in the last 12 months (better than average)
- 91% of staff believing that trust provides equal opportunities for career progression and promotion (better than average)

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated safety of services at this trust as good. For specific information, please refer to the report for Salford Royal Hospital and the Community reports.	Good

Incidents

- A strong culture of incident reporting was embedded within all levels of the organisation. Staff felt empowered to report incidents and recognised the importance of reporting incidents to ensure patient safety.
- Learning from incidents was widely shared across the trust through a variety of mediums ranging from safety huddles to newsletters. There was clear evidence of process change at a trust wide level from local incidents at ward level. Staff at all levels were able to describe learning from incidents at a personal level.

Staffing

- Actual and planned staffing levels were clearly displayed across the trust in accordance with the safer staffing initiative. Staffing numbers and the skill mix across the trusts was sufficient to ensure safe care. Staff worked flexibly to ensure shortages were covered through an internal bank. Agency staff were rarely used. Where agency staff were used, there was a clear induction process to ensure staff were adequately familiar with their working environment.
- The need for further recruitment of suitably trained children's nurses was on the risk register. Contingency plans were made including rotating nurses between the emergency department and PANDA unit.
- Care across the trust was consultant led as evidenced by the fact that a majority of core services had a higher percentage of consultants than national average. There was evidence of innovative staffing within the Emergency Department with the use of Advanced Nurse Practitioners to effectively meet the national shortage of Emergency Department Speciality Trainees

Safety Thermometer

- A quality improvement collaborative was started in 2011 to address the increasing incidence of pressure ulcers in the trust.

Learning sessions for staff were rolled out to improve awareness and a trust wide initiative commenced in 2012. Over a three year period they have achieved a 73% reduction in pressure ulcers trust wide.

Safeguarding

- The trust had a designated clinical and nursing lead for safeguarding. There was widespread adherence to safeguarding training. Through the hospital IT system, patients identified as requiring safeguarding were automatically flagged up for review and staff prompted to complete the essential referrals.
- Completion of mandatory training was included in individual staff appraisals, ensuring compliance with trust policies.

Duty of Candour

- Duty of Candour (DoC) regulation requirements were reported to the Executive Assurance and Risk Committee (EARC), a Standing Committee of the Board (Chaired by the CEO) on 16 December 2014.
- The paper presented to EARC outlined the statutory requirement and the steps the provider needed to take following a notifiable incident in accordance with the trust 'Duty of Candour Procedure' presented to the committee.
- The procedure covered the DoC requirements associated with the trust Serious Untoward Incidents (SUI) and the Serious Incident Action Review Committee Incidents (SIARCS).It described the 'being open' procedure and the fact that the policy should be used in conjunction with the trust 'Being Open Policy'.
- Whilst the procedure referred to SUI and SIARAC covering the notifiable incidents including death, major harm and moderate harm (harm that requires a moderate increase in treatment, and significant, but not permanent harm), it did not refer to the requirements to ensure that DoC was applicable in cases where there had been psychological harm (which was likely to, or had lasted for more than 28 days as a result of an incident. It was unclear how the SUI and SIARAC incidents were mapped to all the relevant notifiable incident categories.
- Prior to the regulation and the paper being sent to EARC, the trust had already implemented part of the process relating to DoC through the functioning of the SIARAC meeting, where the trust monitored its compliance with 'being open' with the patient. This usually resulted in a conversation with the patient and being open about the incident that had occurred.

Summary of findings

- Compliance monitoring had been included within the Datix incident reporting form and a review was incorporated into the root cause analysis of the incident. Adherence to the initial process was reviewed through SIARAC minutes. We saw evidence of the completion of SIARAC review checklists during the inspection.
- The trust advised that they aimed to introduce 'disclosure coaches' going forwards to champion the DoC process, but this had not been implemented at the time of the inspection.

Are services at this trust effective?

Good

Overall we rated effectiveness of services at this trust as good. For specific information, please refer to the report for Salford Royal Hospital and the Community reports.

Evidence based care and treatment

- There was strong evidence of adherence to best practice guidelines in accordance with NICE and the Royal Colleges. Guidelines were easily accessible through the trust intranet page and there was a widespread culture of audit to ensure compliance with these guidelines.

Patient outcomes

- Patient outcomes were being monitored across the trust through participation in line with the HQIP national audit program. Furthermore, regular participation in audits outside mandatory submissions across the Trust ensured that the quality of service delivered was continuously monitored and acted upon. A majority of the metrics were in line with national averages or better. Where outcome data indicated performance below national averages, for example management of fracture neck of femurs and renal colic, improvements to the pathway had been implemented.
- The risk of re-admission post certain elective surgical and paediatric services had been identified as worse than the England average. Innovative interventions such as 'hot clinics' were introduced to improve this.

Multidisciplinary working

- We found a strong culture of shared ownership for patients and effective multidisciplinary working at Salford Royal. This was particularly apparent within the Emergency Department with specialities and allied health professionals providing an in-reach service to ensure high quality care. Bi-monthly cross department MDT meetings took place to ensure collaborative working within specialities.

Summary of findings

- There was evidence of wider working within the local health economy and integration with primary care services to ensure seamless transitions of care.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent across the trust was in line with national guidelines for adults and children.
- There was a disparity in the way that patients who lacked mental capacity were identified, risk assessed and managed. There was variable understanding of the Deprivation of Liberty Safeguards. This was highlighted to the trust and they provided us with a detailed response including actions taken to ensure consistent training of staff.

Are services at this trust caring?

Outstanding ☆

Overall we rated the caring aspects of services in the trust as outstanding. For specific information, please refer to the report for Salford Royal Hospital and the Community reports.

Compassionate care

- Feedback from patients and those close to them were extremely positive about the way staff treated them in terms of compassion and dignity and respect. There was clear evidence that valuing people's individual needs in a holistic manner was a priority for staff throughout the trust.
- The trust was the top acute trust in the In-patient survey in 2013 in six of the ten areas including A&E, Hospital and wards, nurses, care and treatment, operations and procedures and overall views.
- The cancer inpatient survey results showed that the trust was in the top 20% of all trusts nationally for 26 of the 69 questions

Understanding and involvement of patients and those close to them

- People who used the services were actively involved in developing improvements in their care to ensure the care they received was personal. In January 2013 the trust launched a project aimed at improving patient, family and carer experience as part of the patient experience strategy. This resulted in the concept of 'always events', which were things that patients should always expect to happen to them when in receiving care from the trust including;

Summary of findings

- Written bedside communication – such as the intestinal failure team giving their patients a specific pad to note down questions that might occur to them and other teams using a sheet which says “if I had three questions to ask my consultant today”
- Capturing, displaying and acting on patient feedback data
- Enriching what matters most conversations - on admission the trust asked all patients “what matters most to you” and recorded it behind their beds.
- Creating a home from home environment
- Different ways to provide information to patients and their family – such as a key for patients on uniforms to help them understand who they were on the wards
- Improved patient and family access to the staff that look after them – such as ward managers having open door hours for provide specific time for contact for any issues to be raised.

- The Quality Improvement strategy for 2015 to 2018 outlined five aims and one of these was specifically relating to working with patients and carers, which demonstrated the importance the trust placed on the value of these relationships with patients. Aim four involved:
  - ‘Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives’.

Emotional support

- People using the services at the trust were treated as individuals and their specific emotional needs considered including their cultural, emotional and social needs.
- Initiatives were in place to ensure patients individual emotional needs were considered through working in partnership from admission to discharge.
- Feedback from patients and those close to them, in the majority of cases, highlighted the individualised personal care that had been provided.

Are services at this trust responsive?

Overall we rated responsiveness of services at this trust as outstanding. For specific information, please refer to the report for Salford Royal Hospital and the Community reports. Salford Royal Hospital had three outstanding ratings, three good ratings and one core service that required improvement, which resulted in an aggregated rating of outstanding.

Outstanding ☆

Summary of findings

We found the services were tailored to meet the needs of individual people who used the services both in Salford Royal Hospital and across the community. In addition, the services were provided in a flexible manner to provide continuity and integrated care from the hospital into the community setting. There were some areas that required improvement and the trust were aware of these and were taking steps to make necessary improvements.

Service planning and delivery to meet the needs of local people

- There was consistent evidence of innovative practice undertaken by the trust to meet the needs of their local population. This was especially evident within the Emergency Department where there was a strong culture of "in-reach" from medical specialities and in particular a team established to rapidly assess the needs of the elderly frail patient.
- Patients who were identified as requiring end of life care were prioritised and rapid discharge was ensured to their preferred place of care within six hours.
- The hospital had a multi-faith centre which catered to the religious needs of the local population including a non-denominational 'Oasis' room.
- The bereavement team at the hospital worked closely with the local police to provide support to relatives in situations of sudden deaths, road traffic accidents and suicides across the city.
- The patient journey through the department and waiting times for patients who required assistance following appointments to return home meant that some patients were receiving a poor experience in the service. Furthermore, lone working in the ambulance lounge left staff vulnerable to patients who were aggressive. We saw evidence of this during the inspection.
- The critical care department provide a combination of ward, telephone and outpatient multidisciplinary follow up service. They contributed to the development of NICE guidelines (2009) on critical care rehabilitation. They proactively gather feedback on the service for evaluation.

Meeting people's individual needs

- In collaboration with Age UK, the trust provided support for residents aged 60+ when they were admitted to the emergency department. All patients discharged from A+E would be followed up by volunteers from Age UK to ensure that they were managing with daily activities.

- Patient whiteboards placed above patient beds were updated daily to provide bespoke care. Information included things important to patients and identifiable names of staff responsible for care.
- A blue butterfly symbol was introduced within the trust to identify service users with cognitive impairment. Patients identified as such, were visited by dementia specialist nurses who also co-ordinated training for staff members on dementia awareness. All wards had a dementia champion.
- Patient passports were in use across the trust, including passports in different languages. Modifications, such as colour coding of bays and clear displays of the date and time were available to aide cognition for patients.
- Within oral surgery, dedicated lists were established for patients with learning disabilities, to ensure adequate support.
- Patients with learning disabilities attending the outpatient department were given afternoon slots, when there were increased staff numbers to assist patients. Furthermore, they were actively prioritised to the beginning of a clinic list to minimise time spent in unfamiliar environments.

Access and flow

- We saw good practice within the Emergency Department in response to increasing A+E attendances and issues with flow through the department. This included successful reorganisation of the layout of services through relocation of the minor injury unit and engagement with the local CCG's and Council. A dedicated 'deflector' ensured patients being treated in the most appropriate setting with dedicated GP appointment slots agreed with local primary care services.
- The acute medical unit was well established and led the way in embracing the national four hour target as 'everyone's business' and not just the responsibility of the A&E department.
- Concerns regarding the movement of children requiring inpatient admission to neighbouring hospitals were identified within the risk register. It was not clear how parents/carers were made aware of the limitations of care and treatment that could be provided to their children.
- Referral to treatment times on the 18 week non-admitted pathways were not met across all specialities. Patients had waited an unacceptable time for results of MRI scans. Although the department had worked hard to rectify the issue, they were unable to provide robust assurance that the issue had been addressed in the longer term.

Summary of findings

Learning from complaints and concerns

- The trust had a rigorous complaints answering process to address both formal and informal complaints. Each department had a lead nurse in charge of reviewing and acting on complaints and disseminating the learning from the complaints through safety huddles and newsletters.
- Within the response to service users, a formal letter of apology was included when things had not gone in accordance with plans.
- Patients had access to a free 24 hour helpline, staffed by a senior member of the trust team. This was clearly signposted on all wards and the trust was committed to provisionally responding to all complaints within an hour.

Are services at this trust well-led?

Outstanding ☆

The overall trust leadership was rated as outstanding. For specific information about leadership within the hospital and the community services please refer to the report for Salford Royal Hospital and community services reports.

Salford Royal Hospital leadership was rated as good overall with three core services that demonstrated outstanding leadership and two that required some improvements to be made. The community leadership was rated as outstanding overall, as well as trust-wide leadership was evident to be outstanding. The aggregation of these judgements for assessing well-led at provider level is outstanding overall.

The strength of leadership at senior level, the governance processes and the focus on reducing patient harm to ultimately achieve the ambition of being the safest trust in the NHS was evident through a positive culture to deliver high quality care, with a clear focus on quality improvement and measurement for improvement. Innovation to improve safety was proactively encouraged.

The corporate objectives to provide safe, clean and personal care every time was meaningful to staff and underpinned improvement strategies throughout the organisation in a measurable way through the quality improvement monitoring. The trust had achieved significant improvements in the quality of care set out in their strategy from 2008 to 2014 and they had set out five clear objectives for the trust from 2015 to 2018. The strategies in both set out challenging and innovative objectives that could be measured as clear indicators of success.

Summary of findings

In addition to these strategies, the trust also worked in a collaborative and systematic way with other providers across Wigan, Bolton and Salford to review pathways of care provision across the wider region to address issues of sustainability, value for money and improving patient care.

The trust values were aligned to HR processes and the performance management strategy. The behaviours they were seeking included being respectful, accountable, patient centred and being committed to continuous improvement, which were reflected in financial incentives (e.g. Clinical excellence awards and increments) and are assessed through appraisal.

Governance arrangements were standardised and were able to respond where any improvements were needed in a proactive manner. Clinical governance was well embedded throughout the organisation and all staff groups were aware of systems and processes.

The ward level clinical standards and ratings were assessed through the Nursing Assessment and Accreditation System (NAAS), which allowed wards to be assessed and gain a rating of red, amber or green. The assessments took place every eight months and where a ward achieved green status on three consecutive occasions (over two years) they were awarded SCAPE (Safe, clean and personal, every time) status.

Quality improvement was a clear focus for the trust through collaboration across all staff groups in quality improvement methods to reduce patient harm, improve outcomes and patient experience. One 'collaborative' focussed on gathering patient views across the whole pathway of care from prior to admission to the community to make improvements.

The leadership at board level was recognised by staff as inspiring and providing a clear vision. The executive team were visible and 'worked with' staff to understand the organisation from ward to board. The leadership clearly encouraged improvements and provided incentives for staff to make improvements.

There was an open and transparent culture with a focus of improvement, with around half of staff having taken part in a collaborative or microsystems project. The trust performed best in the country for the staff survey and staff were seen to be proud to work for the trust and felt supported in their development.

Vision and strategy

- The trust launched their ambition to be the safest trust in the NHS by providing 'safe, clean and personal care to every patient

every time' in 2008.This continues to be the trust's focus and the **'safe, clean and personal'** corporate objectives well embedded and meaningful to staff at all levels throughout the organisation.

- Having made significant progress against their trust strategy to achieve this ambition between 2008 and 2014; the trust had approved their 'Saving Lives, Improving Lives: The Safest Organisation in the NHS Quality Improvement Strategy for 2015-2018' which outlined the continued drive to provide 'safe clean and personal' care every time and has five main aims:
  - No preventable deaths
  - Continuously seek out and reduce patient harm
  - Achieve the highest level of reliability for clinical care
  - Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives
  - Deliver innovative and integrated care close to home, which supports and improves health, wellbeing and independent living
- The trust provides services across the hospital community and primary care, with their aim to provide integrated healthcare across the organisation is evident within the structure with divisions such as Salford Healthcare combining urgent, emergency and acute medicine in the hospital and across their community services.
- In addition to the trust local strategy, there was also a wider strategy relating to integration across Wigan, Bolton and Salford considering the wider implications and needs of the population across providers in primary and secondary care. The executive medical director had spent the previous year working across Greater Manchester developing the wider strategy with other providers through collaborative working relationships to integrate provision of healthcare across the region.
- Looking longer term, the trust was considering models of care in line with the Dalton Review, to expand their methodology for improvement, standard setting and leadership development.
- The trust values were '**patient and customer focus, continuous improvement, accountability and respect'** and these formed part of the performance framework, which reviewed how staff performed against each of the values in their behaviours and work through the appraisal process. In addition, assessments against these values were reflected in financial incentives (e.g. clinical excellence awards and increments).

Summary of findings

Governance, risk management and quality measurement

- There was a governance structure with standardised systems and processes used within the divisional structures to manage risk, clinical governance and to drive improvements.
- There had been some isolated examples of lapses in governance and monitoring, and the trust were aware of these. However, once these aspects were identified the board was aware and these were being addressed in a transparent manner.
- Areas of clinical governance led by the Director of Nursing (DoN) and her teams were seen to a specific area of strength. The ward level clinical standards and ratings were assessed through the Nursing Assessment and Accreditation System (NAAS), which allowed wards to be assessed and gain a rating of red, amber or green. The assessments took place every eight months and where a ward achieved green status on three consecutive occasions (over two years) they were awarded SCAPE (Safe, clean and personal, every time) status. In order to ensure the standards were maintained this status could be removed at the next assessment if a green rating was not achieved.
- The NAAS system required the transparency of each ward to display key indicators on their ward which was available for patients and their families or carers to read on easily visible boards. Clinical performance in all areas was available at ward level and presented to the board. At the time of the inspection 29 wards had achieved SCAPE status, 15 were green and only 2 were amber.
- The trust had extended the accreditation system to the community teams (CAAS), which they developed in conjunction with staff with specific metrics relevant to the community setting.
- Governance and performance management arrangements are proactively reviewed to ensure they were robust, including external review commissioned by the organisation in 2012/13.
- The governance structure also includes joint management boards with other providers where appropriate to develop the pathways and care provided between organisations.
- The Non-executive directors play a significant role in the governance processes and there was clear evidence of constructive challenge and support.
- The Council of Governors demonstrated clear evidence of holding the non-executive directors to account on performance

in a collaborative and constructive manner; as well as representing the views of patients and the public through formal channels to ensure they received feedback on any concerns or suggestions for improvements.

- The Clinical Effectiveness Committee reviews all national guidance and requires a review to be completed within three months outlining compliance and non-compliance with action plans necessary to drive required improvements.
- There were monthly morbidity and mortality meetings within the divisions, which aimed to drive improvements where necessary at a local level. In addition, there were six monthly trust wide morbidity and mortality meetings where actions plans from the divisional meetings were reviewed and cross divisional learning was shared to encourage trust wide learning and improvement.
- The trust has worked in conjunction with other acute providers on the management of incidents and learning form incidents across multiple provider sites to promote wider learning.
- The trusts annual plan for principle objectives and KPI's were clearly documented for 2014/15 with executive leads assigned to principle objectives, which were monitored through agreed KPIs.

Leadership of the trust

- The executive team had the balance of longstanding members of the team ranging from the CEO (12 years) and DoN (10 years) providing stability to more recent appointments in May 2014 for the Director of Finance and Director of Service Strategy and Development.
- The Chair had been in post for over seven years and had recently been appointed to another three year term, with clear evidence of understanding the future strategy of the organisation in the short and medium term, with a particular focus on clarity of roles and responsibilities.
- The non-executive team also had a balance of those who had been in post longer terms and those more recently appointed. There had been a conscious decision for each individual non-executive not to take one lead role, but for them all to be responsible for all aspects of quality and improvement. There were extensive examples of how this worked within the governance structure and from a leadership perspective effectively. In addition, as a team there was evidence that there was constructive challenge and reflection to continuously improve as a board.
- The CEO, Sir David Dalton, had provided clear leadership regarding the ambition for Salford Royal Hospital in 2008 in

relations to becoming the safest trust in the NHS. He has also led a recent national review, the Dalton Review, which has provided the trust with clear and tangible insight and leadership in relation to the future strategy for Salford Royal NHS Trust in line with their strategy.

- The DoN (Deputy CEO) provided leadership when the CEO was engaged in national work and was well recognised by staff as a fundamental part of the success of Salford Royal Hospital in conjunction with executive colleagues.
- The CEO and the executive team were highly visible and known to staff at all levels. The executive team 'worked with' staff at the frontline rather than 'walk about'. Recent examples included the CEO shadowing a community nurse.
- The trust has both an executive medical director, who worked clinically within the A&E department and provided strategic relationships with partners and external bodies; and an operational medical director who worked clinically as an acute physician and provided clinical operational leadership across the trust.
- Each clinical division had a triumvirate leadership team, which had the clinical Chair as the person with overall accountability and responsibility for their division. In addition, each division had an assigned executive lead, such as the Director of HR or DoN, who provided support and challenge in the performance and development of their division.
- They have also built very good working relationships with their Council of Governors, with clarity about roles and purpose, so that governors contribute significantly to the success of the trust.
- The trust have developed a range of leadership programmes aimed at different levels of staff including;
  - higher leadership programme
  - programme for new consultants
  - TICKLE (Trainees Improving Care though Leadership and Education) for junior doctors.

Culture within the trust

- The trust has some of the best scores in the country on the NHS staff survey being placed in the top 20% for 23 of the 30 questions and none in the lowest 20% of questions.
- Staff across the trust in all staff groups showed a sense of pride in their work and felt proud to be part of the organisation.
- There was good evidence of collaborative multidisciplinary working, which was clear in the quality improvement work where staff jointly demonstrated a drive to improve patient care.

Summary of findings

- Staff in all the focus groups we held were very positive about the trust and the support provided and the investment made in staff to develop. Senior management spoke about 'deep engagement' with staff.
- There was an open and transparent culture, with a real commitment to learn from mistakes. This is reflected in the high level of reporting of incidents with no harm or low harm.
- There was a strong sense of a continuous drive for innovation and improvement in the culture, which was recognised as an environment that may be pressurised for some staff; however the significant majority of staff welcomed that culture.
- Over 50% of staff had been involved in a quality improvement collaborative or microsystem project, which demonstrated the commitment from staff in the culture of improvement.

Fit and Proper Persons

- Fit and Proper Person Requirements (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) were reported to the Executive Assurance and Risk Committee (EARC), a Standing Committee of the Board (Chaired by the CEO) on 16 December 2014.
- The paper presented to EARC outlined the FPPR requirements and the changes that needed to be made to policies, appointment criteria and documents to ensure the trust met the requirements outlined in the regulation.
- The paper proposed enhancements to the Board of Directors' Code of Conduct, to include the process for removal of a director under the fit and proper persons test, and the pre-employment and annual fit and proper persons declaration
- The paper also proposed enhancement of the Management of Employment Checks Policy, to include an additional section on employment checks for Director and Director level posts as part of the assessment that they are a Fit and Proper Person, for Executive and Non-Executive Directors and for other staff classed as Directors regardless of voting rights and including interim appointments, which included:
  - Full DBS check with registration to the Disclosure & Barring Service Update Service alert system to notify of any change in status for any Directors acting in a role that falls within the definition of Regulated Activity
  - Standard DBS check for other Directors
  - Review of core public information sources regarding providers that the appointee has had a role with them in accordance with CQC guidance issued in November 2104

  - Check with appropriate professional bodies if the person to be appointed has erased, removed or struck off a register of professionals maintained by a regulator of healthcare or social work
  - Check on Gov.UK if the person to be appointed is an undischarged bankrupt or a person who has had sequestration awarded in respect of it and who has not been discharged or similar restrictions in Northern Ireland or Scotland and annual re-check
  - Check with Companies House if the person to be appointed is a disqualified director and annual re-check
  - Where only a basic reference is provided for the person to be appointed further information will be sought from the organisation providing that reference
  - Skills and competencies will be tested through the appointments process
- The process outlined involved results being provided to the chair to allow them to that all the checks have been undertaken to reach a judgement that a proposed director meets the Fit and Proper Persons Test (FPPR) before employment or engagement is confirmed.
- The process requires completion of the 'Fit and Proper Persons Declaration' prior to appointment, and annually thereafter.
- In addition, it was stated that the Executive Director Contract/ Non-Executive Director Agreement needed to be revised to allow for termination in the event of non-compliance with fit and proper persons test.
- The actions stated that:
  - During December all Board-level Directors were asked to complete, sign and return the revised Board of Directors Code of Conduct, including completion of the annual fit and proper person declaration.
  - The Trust recognises that DBS checks are required as part of this process and was processing and updating all DBS checks for all Director posts at the time of the inspection.
- We were advised that an update was scheduled to be presented to EARC following the inspection.

Public and staff engagement

- The staff survey showed that the trust was in the top 20% for the following indicators relating to engagement of staff in their work:
  - Percentage of staff reporting good communication between senior management and staff
  - Percentage of staff able to contribute towards improvements at work

  - Staff motivation
  - Staff job satisfaction
- During the inspection and focus groups, staff described the trust as somewhere they felt they were listened to and were engaged in the future strategy of the trust.
- The Patient and Staff Experience Committee consider aspects relating to patients and staff.
- There were numerous examples where staff were engaged in the decision making or future strategy of the trust, particularly regarding quality improvements.
- Patients and public voice was heard through a number of sources including the Council of Governors feeding information into the trust on views and experience from the public, with clear processes for feedback.
- In January 2013 the trust launched a project aimed at improving patient, family and carer experience. It focussed on the views of patients through all parts of the patient journey, including before admission to discharge and community healthcare, as part of the wider Patient Experience Strategy. The project has used the concept of 'always events' (i.e. things that our patients should always expect to happen to them when in our care).
- In September 2014, the project had its seventh Learning Session where an interim change package was launched. This change package included changes that had been tested by the teams involved in the project, who then recommended them to other areas to adopt and test further before they were implemented more widely across the organisation.

Innovation, improvement and sustainability

- The trust has a clearly defined Quality Improvement Strategy that they have measured themselves against, which was launched in 2008 with evident successes. In addition, the Quality Improvement Strategy for 2015 to 2018 outlined key achievements and objectives.
- The approach to service improvement at Salford Royal is through a learning collaborative approach based on Plan, Do, Study, Act (PDSA) cycles is deeply embedded throughout the hospital and strengthening in the community setting since integration of community services took place.
- The trust had invested in the infrastructure needed to sustain these quality improvement initiatives, but firmly believe that this represents very good value for money through measurable improvements in care and reductions in avoidable harm.
- Measurement for improvement from ward to board was a key aspect of the Quality Improvement Strategy which included;

  - Quality Dashboard – presented to board and recently been updated to help understand variation throughout the hospital.
  - Service Level dashboards – in specific areas involving 'deep dive' Quality Dashboards such as the Spinal and Trauma & Orthopaedic services
  - Education regarding Measurement for Improvement as a key foundation of our learning sessions.
  - Leadership Programme – the Quality Improvement team has a session of at least half a day on our Leadership Programme.
- The trust has instituted a system of SMART savings, which is a system where staff who recommend a change that is implemented and leads to a subsequent saving receive a share of the saving.
- An initiative that had been put in following an incident, included a helpline phone by patients' bedside, which enables them to bring concerns to the attention of a senior nurse to ensure families and carers views were heard effectively and in a timely manner.

Electronic Patient Record (EPR)

- The trust has an electronic patient record system (EPR), which staff were strongly supportive and told us that it contributed to patient safety through informed decision making and safer handover. The hospital is currently paper-light in some areas and near to paperless in other areas.
- The developments in terms of ESR are not as advanced in the community provision; however there were clear plans of engagement with staff in the community to look at developments in line with their needs. They wished it could go further and faster, especially in terms of extension to the community, which is planned.

Overview of ratings

Our ratings for Salford Royal Hospital are

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

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Outstanding	Good	Outstanding	Outstanding
Community health services for children, young people and families	Good	Good	Good	Requires improvement	Good	Good
Community health end of life care	Good	Outstanding	Good	Outstanding	Outstanding	Outstanding
Overall	Good	Good	Good	Good	Outstanding	Good

Overview of ratings

Our ratings for Salford Royal NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

- Nursing assessment and accreditation systems (NAAS) provided the trust board and patients a high level of transparency in relation to clinical performance indicators and measures. This information was publicised throughout the wards and clinical areas for people to consider and scrutinise.
- In conjunction with the NAAS initiative, staff spoke positively about ensuring that patients received safe, clean and personal care every time (SCAPE). SCAPE was described as a process lasting 24 months and involving three separate assessments whereby staff delivered on a range of patient focused competencies and considered a range of performance indicators. The accolade of SCAPE was seen as significant success by clinical leaders and ward based staff.
- There was clear evidence that the development of the 'emergency village' with its integrated care pathway approach, including medical in-reach, continued to deliver improved outcomes for people.
- Quality improvement initiatives had successfully led to a reduction in the number of hospital acquired pressure ulcers.
- Staff were encouraged to undertake research, for example, we reviewed a paper published in respect to improving patient care in a national intestinal failure unit.
- The surgical division celebrated the positive arrangement they had for the movement of elective orthopaedic work off site and anticipated this would improve patient throughput, standardise use of prosthetics and develop a centre of excellence.
- The surgical division indicated they had established a link with Central Manchester NHS Foundation Trust, which they anticipated could lead to future partnership working in their developed Manchester Orthopaedic Centre. This was expected to lead to increased pooled volumes of specialist activity with standardised practice leading to improved patient outcomes.
- The surgical division annual plan described the development of a service model for emergency and complex surgery with two other NHS providers.
- We saw in the theatre staff newsletter produced for December 2014 an introduction to the forthcoming 'Theatre Improvement Programme'. We were told this was due to commence at the end of January 2015, with the aim of ensuring theatres could provide safe and reliable care, provide value and efficiency and deliver a high team performance with high team morale and well-being. This work was being co-ordinated and delivered through a Quality Improvement methodology, led by a steering group headed by the Director of Organisational Development and Corporate Affairs. We saw from information provided to us that the programme was based around the Productive Operating Theatre model, developed by the NHS Institute for Innovation and Improvement.
- The senior managers within the surgical directorate recognised the areas for further focus, which included interventional radiology, middle grade recruitment to medical staff, the delivery of complex emergency care and making improvements to the discharge process, by reviewing and enhancing the patient pathway.
- There was an incentive for staff who wished to be involved in helping the trust to make financial savings to the service. If an idea was adopted, the staff member received 10% of the overall savings as a reward for their innovation.
- Rotating junior staff to other areas across the critical and high dependency care units to facilitate personal progression and encourage staff retention.
- Bleeps were provided to relatives in order that they could be contacted quickly by staff if they were away from the CCU.
- The diabetes outpatient service demonstrated good practice where children in transition from young people to adulthood were seen in a clinic attended

Outstanding practice and areas for improvement

by an adult physician and adult specialist nurses, giving dietetic and psychological support. This ensured a continuous and consistent pathway of care through to adulthood.

- We were told the trust was actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. The Trust had piloted the use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB) which were used to support patients that are assessed as acutely unwell deteriorating, with limited reversibility and where recovery is uncertain however it was decided not to continue to implement the ACB after the pilot.
- Other improvement areas include Advance Care Planning (ACP), EPaCCS, rapid discharge pathway, meeting the priorities for care of the dying person and effective care after death including bereavement and mortuary service.
- Innovative work undertaken included the access to seven day Specialist Palliative Care for SRFT since 2009 (only 21% of trusts deliver this nationally). The trust has participated in all 4 rounds of the NCDAH and the trust was described as above the national average for 9 out of 10 Clinical KPI's. The bereavement care delivered across the trust and the trusts awareness around cultural needs of the population were well met by the HSPC, bereavement and the chaplaincy teams.
- The system of daily safety huddles, and intra-team situation reports ensured that important information was passed between teams and shifts.
- The team-based audit programme and the monitoring of results and actions.
- The Community Assessment and Accreditation System, and arrangements for gathering patient feedback.
- The mandatory training and professional registration monitoring systems.
- The system of competency assessment and associated records.
- The use of the "Butterfly Scheme" for people living with dementia.
- The arrangements for ensuring the safety and security of lone workers in community adult services.
- The Care Home Medical Practice was a beacon of innovation and excellence, reducing unplanned hospital admissions and supporting people to remain in their preferred place of care until their death.

Areas for improvement

Action the trust MUST take to improve

- The trust must take action to ensure that WHO safety checks (or equivalent) are conducted on all patients going through operating theatres and must take action to ensure that monitoring of WHO safety checks are carried out.
- The trust must ensure that the environment is appropriately maintained and fit for purpose; the main out-patient department experienced a regular leaking roof in several areas, and sewage leaks through the ceiling.

Action the hospital SHOULD take to improve

- The trust should ensure that safety checks on technical equipment used in the delivery of treatment and care to patients is carried out routinely. This is something that is required as part of Regulation 16, safety, availability and suitability of equipment. It was considered that the omissions related to the checking of anaesthetic machines by theatre staff was not proportionate to support a judgement of a breach of the regulation.
- The trust should ensure that the knowledge and application of the Mental Capacity Act and the Deprivation of Liberty Safeguards is consistently applied across all services.

Outstanding practice and areas for improvement

- The trust should ensure that it makes consideration of improving the discharge process to patients from the wider geographical area, beyond the local service area.
- Whilst we acknowledge that the Trust has embarked on a programme of quality improvement within theatres to improve the culture and morale, the trust should ensure that this initiative is both effective and sustainable so that changes are fully embedded for the future.
- The trust should consider ways of reducing the rate of surgical procedure cancellations.
- The trust should consider a unified strategy for the delivery of children's services, both medical and surgical; governance systems, risk management and performance measurement processes should be standardised to ensure children receive quality, evidence based care.
- The provider should consider arrangements for the management of patient records at Walkden Gateway.
- The provider should consider how discharge information between the acute and community sectors could be made more effective.
- The provider should ensure that patient records at Swinton Hall are appropriately secured and kept safe.
- The provider should review its current storage arrangements at Heartly Green to ensure equipment is stored appropriately and safely.
- The provider should review existing arrangements with regards to the supply of medicines at Heartly Green to ensure medicines are made available without unnecessary delay.
- The provider should ensure that all Control Drug log books are maintained in line with national requirements.
- The trust should review existing pathways to ensure that children who were not in mainstream education were appropriately identified in order that their health and development needs can be identified and assessed in line with national programmes.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used the service were not protected against the risk of receiving care or treatment that was inappropriate or unsafe. This was because the planning and delivery of treatment and care did not ensure the welfare and safety of patients in the operating theatres. Further, such risks did not take into account appropriate published research evidence and guidance as to good practice in relation to treatment and care. Regulation 9(1)(b)(ii) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who used the service and staff were not protected against the risks associated with unsafe or unsuitable premises. 15.(1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of (a) suitable design and layout; (c) adequate maintenance and, where applicable, the proper— (i) operation of the premises Regulation 15 (1)(a)(c)(i) Health and Social Car Act 2008 (Regulated Activities) Regulations 2010