The Pennine Acute Hospitals NHS Trust

Evidence appendix

Trust Headquarters
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Date of inspection visit:
17 October to 16 November 2017

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xxxx> 2017

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Background to the Trust

The Pennine Acute Hospitals NHS Trust serves the communities of North Manchester, Bury, Rochdale and Oldham, along with the surrounding towns and villages. The area is the Northeast sector of Greater Manchester and has a population of around 820,000.

The trust provides a range of elective emergency, district general services, some specialist services and operates from four sites: North Manchester General Hospital, The Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary.

The trust provides services in the following specialties: urgent and emergency care, medicine, surgery, women and children, diagnostics, specialist services and community services. The major services are on two sites at North Manchester General Hospital and The Royal Oldham Hospital, each serving a population of approximately 400,000. The trust’s main commissioners are NHS Bury, NHS Heywood, Middleton and Rochdale, NHS Oldham and NHS Manchester.

At the last inspection in August 2016 the trust was rated overall as ‘inadequate. There were serious concerns the trust did not have an understanding of its key risks at departmental, divisional or board level. In a number of services, including accident and emergency (A&E), maternity, children’s and critical care, key risks were not recognised, escalated or mitigated effectively. We had found significant shortages in nursing, midwifery and medical staff.

We found performance reporting was inconsistent; this had been acknowledged by the trust and work was underway to address this, however, this work was still in its early stages at the time of the 2016 inspection. We also had concerns in respect of the quality of data provided to support performance reporting. We did not see any evidence of testing data quality in respect of performance monitoring and management.
Following the August 2016 inspection, a team of senior health executives from Salford Royal Foundation Trust, with external support, undertook a diagnostic review of risk to patient safety. The focus was to identify areas for improvement that affected patient safety informed by the immediate concerns raised by the CQC. This was a nine-month plan launched in the autumn of 2016 with a focus on the services rated as inadequate.

Since the inspection in August 2016, a new leadership structure has been put in place, with one Board of Directors across Salford Royal Foundation Trust and Pennine Acute Hospitals NHS Trust (collectively called ‘Group’). There are four distinct care organisations in this Group: Oldham, Bury/Rochdale, North Manchester and Salford. Each care organisation has its own leadership team who report into the Group Board, called Committees in Common. This new Group arrangement is called the ‘Northern Care Alliance NHS Group’.

Facts and data about the trust

The trust employs over 9,000 staff and has a total operating budget of over half a billion pounds for the current financial year 2017/18.

The trust provides a full range of acute and community adult clinical services. The trust has 1,068 general and acute beds, 129 maternity beds and 45 critical care beds.

From August 2016 to July 2017, the trust had:

- 322,105 A&E attendances
- 773,729 outpatient attendances
- 165,689 inpatient admissions
- 8,779 baby deliveries
- 2,500 deaths

Maternity and Mortality Outlier Alerts

There was currently one active mortality alert for the trust: Acute cerebrovascular disease (Dr Foster, January 2016).

There were currently no maternity alerts.

(Source: CQC Insight July 2017)

What people who use the trust’s services say

Feedback from adult inpatients (aged 16 or over) that spent at least one night in hospital during July 2016 showed:

There were no areas where patient experience had improved from 2015 to 2016. There were three areas, which had declined from 2015 to 2016:

- Receiving enough help to eat meals
- Staff explaining side effects of medication
- Told how to expect to feel after operation/procedure

There were no areas better than expected in both years. There were no areas worse than expected in both years.

In the cancer patient experience survey 2016, the trust was in the top 20% of all NHS trusts for 18 out of 34 questions and in line with the middle 60% of trusts for the remaining questions.

Overall, compared to 2016, the 2017 patient led assessments of the care environment showed the trust performed better than the England average for cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance and disability access. The dementia friendly domain scored worse than the England average, however, this domain showed a 10% improvement compared to 2016.
Is this organisation well-led?

Leadership

The leadership and organisational structure had changed since the last inspection. In April 2017, the Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust Boards of Directors set up the Group Committees in Common, with delegated responsibility for the exercise of functions of both organisations. The Chairman plus six non-executive directors and six executive directors made up the Board and Committees in Common.

There were four new care organisations covering North Manchester, Bury/Rochdale, Oldham and Salford. Each care organisation had a Medical Director, a Director of Nursing, Managing Director, Chief Officer and a Finance Director. Each care organisation was responsible to the Group for the day-to-day running of the hospital and community service of a care organisation.

The senior leadership team had the skills, knowledge, abilities and commitment to provide high-quality services. This was being embedded through the care organisations to the different management levels in the trust, however, this was still being developed and required further work to ensure the new leadership structures were effective across all of the hospital sites.

The clinical directors had been allocated time in job plans to develop leadership skills however; this was work in progress to ensure consistency across the organisation.

Our discussions with the leadership team demonstrated a level of awareness of the priorities and challenges facing the trust. The challenges to quality and sustainability were understood by the leaders and articulated through the operational plan. Senior leaders spoke with insight about staffing, which they noted as their biggest challenge to quality. This was recognised in the corporate risk register and Board Assurance Framework.

There was a Leadership and Management Development Strategy 2015 – 2020. This set out a framework to strengthen leadership development through investment in behavioural-based leadership and coaching programmes and embed supportive leadership styles. Care organisations were developing succession plans for business critical roles in their areas to attract the best talent and become an employer of choice. The trust was working to enhance the appraisal process and develop a behavioural-based assessment feedback tool to provide information to leaders and managers on impact and effectiveness. A new Clinical Leadership Programme for ward managers and junior sisters started in April 2017, sponsored by the Executive Chief Nurse.

The non-executive directors had a variety of skills, knowledge and experience, which was relevant to their roles. We spoke with four non-executive directors and all were positive about the effectiveness of the trust leadership team; they felt it was stronger than it previously had been. They told us they felt able to challenge the director team if needed. The non-executive directors met before each Committees in Common meeting to discuss the agenda and there was a debriefing with the Chair to identify and follow up the key risks through the various sub-committees.

The non-executive directors were engaged in quality governance, although the non-executives did not sit on the assurance committees to the Trust Board, apart from the Audit Committee. We felt they were sighted on most issues and did provide appropriate challenge.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. We observed a Committees in Common meeting and the meeting started with a patient story. A lead from each care organisation presented action taken in response to key areas of risk, including A&E standards, cancer waiting times and financial performance. There was an update on the CQC improvement plan. We observed that the meeting was well chaired and the non-executive directors gave constructive and informed challenge.

The trust appointed a shadow group council of governors. Governors attended the Committees in Common and other committees. There was a Governors Board with a lead Executive Director. The lead governor had a regular meeting with the trust chair. Governors said they had the ability to challenge and hold the non-executives to account for the performance of the Board of Directors.
Performance appraisals for non-executive directors went to the Nominations, Remuneration and Terms of Service Committee. The Council of Governors approved the process. The Chairman was peer assessed by members of the Board of Directors and Governors. The Chairman held annual appraisals and performance reviews for non-executive directors.

The trust met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We looked at executive, non-executive and care organisation director employment files, which were completed in line with the FPPR regulations.

The chief pharmacist was aware of the challenges to the quality and sustainability of the pharmacy service and had taken steps to address these. There was a chief pharmacist for the North East sector organisations and one for Salford and remained visible and approachable to staff. During interviews with staff, some concerns were expressed about the lack of a Director to represent Allied Health Care Professionals. There was a feeling by this staff group that they had been ‘forgotten about’. We raised this with the Chief Nurse, who confirmed that they were looking to develop a Director of Therapies to improve the ‘therapy voice’ at group level.

The table below shows the structure of the Board:

**Board members**¹

- Of the Pennine Acute NHS Trust executive board members at the trust, none were black and minority ethnic (BME) and 25% were female.
- Of the Pennine Acute NHS Trust non-executive board members, none were BME and half were female.
- Of the Committee in Common group executive board members at the trust, 16.7% were BME and 33.3% were female.
- Of the Committee in Common group non-executive board members, none were BME and 42.9% were female.

<table>
<thead>
<tr>
<th></th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive (PAT)</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Non-executive (PAT)</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Total (PAT)</td>
<td>0.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Executive (CiC)</td>
<td>16.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Non-executive (CiC)</td>
<td>0.0%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Total</td>
<td>7.7%</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

**Vision and strategy**

There was a clear overarching strategy and vision, but the trust was not yet in a position to have a ‘bottom up’ approach to strategy development through the clinical teams, due to only just establishing clear Clinical Director roles.

The trust was delivering a number of internally focussed change programmes to transform services and ensure that the organisation was clinically and financially sustainable in the future.

The trust had a key role as a partner in the transformation of services across Greater Manchester Health and Social Care services and the wider health system. A number of wider change programmes were also underway across the wider health and social care economy.

¹ RPIR – Universal: Board tab
The trust had a Quality and Safety Strategy, which worked alongside the Leadership Strategy, Workforce Strategy and Organisational Learning Strategy. The strategy was developed using the recommendations of several projects in the trust; these included CQC inspection, incident reporting, mortality reviews, Emergency Care Improvement Programme reviews, Dr Foster diagnostics, patient and staff survey results, and the key priorities viewed by front line staff and leadership. The key objectives included no preventable deaths, reduce patient harm, achieve the highest levels of reliability in clinical care and deliver innovative and integrated care close to home.

We observed projects outlined in the quality strategy being implemented on the wards. Examples included: end PJ paralysis (helping patients to get up and moving), introduction of national systems to recognise deteriorating patients, reliable ward rounds, venous- thromboembolism assessments and redesign of the Medical Assessment Unit to include frailty.

A programme was underway to develop a ‘North East Sector Acute Clinical Service Strategy’. The programme was to run until the end of 2017/2018 and conclude with an Acute Clinical Service Strategy. The aim of the strategy was to show how clinical and financial sustainability will be achieved for Fairfield General Hospital, Rochdale Infirmary and The Royal Oldham Hospital, and support North Manchester General Hospital. The trust completed a stocktake of services by each of its care organisations, which provided a baseline for the development of the Clinical Services Strategy for each care organisation and the Group.

The trust completed a Mortality Review Strategy 2017-2019 to undertake a proportionate review of all cases where patients have died, recognising where the organisation or delivery of patients’ care could have been better and making the appropriate changes to deliver improvements. The vision underpinning the strategy was to ensure high-quality review of cases of mortality, and lessons learned as a result, were embedded in the trust’s clinical governance framework.

The trust completed an organisational workforce review, paying particular attention to the fragile services: maternity, urgent care, critical care, and paediatrics. This led to the recruitment of nurses, midwives, consultants and junior medical staff. The trust was continuing to recruit to vacancies through international, local and national recruitment opportunities. There was a weekly dashboard; this identified by ward; nursing fill rates, harms, sickness and vacancy rates identifying possible harm relating to nurse staffing levels and skill mix.

The trust had a Dementia Strategy, aligned to the trust’s vision, and a quality strategy. However, the delivery of person centred care in the recognition, assessment, investigation and care planning for patients with cognitive impairment, mental health or learning disability was not consistent in all areas.

Each care organisation had a vision and strategy. This focused on patient safety, the development of the workforce, the development of pathways outside the trust environment and continuing to build on the current successes. Staff and managers told us that the focus of the hospital had changed from target-focused services to patient centred services. Most staff we spoke with were aware of the vision and strategy for their areas. The chief pharmacist had a vision for service development supported by a medicines optimisation strategy; this was due for review in May 2018.

Culture

There was a re-design of operational management structures, developing a culture of quality and service improvement.

Most staff we spoke with described a continued improvement in the culture since our last inspection and spoke positively about the leadership team. There were cultural challenges with some clinical groups, particularly surgeons across the trust, but the senior team were fully aware of this.

The trust had appointed a ‘Freedom To Speak Up Guardian’ and provided them with sufficient resources and support to help staff to raise concerns. The Freedom to Speak Up Guardian from Salford had recently taken up the post at Pennine. The trust was recruiting local guardians, who would be in post in January 2018. There was a non-executive director for Freedom to Speak up.
Currently there were 34 cases the majority being Human Resource issues mainly around bullying and harassment.

The trust applied duty of candour appropriately. Staff we spoke with were aware of the statutory duty of candour principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We looked at ten serious incident investigation reports and found that duty of candour was applied.

The Director of Patient Safety was responsible for duty of candour. Duty of candour was monitored in the weekly serious incident meeting chaired by the Director of Patient Safety and representatives from each care organisation. Evidence of serious incident compliance for duty of candour was shared with Clinical Commissioning Groups and the Group Executive Assurance and Risk Committee.

The NHS Staff Survey 2016 results were shared with divisional and care organisation leadership teams. The results were also reported to the Trust Board, Workforce Committee and the Commissioner’s Quality Board. Quarterly pulse check surveys measured actions, which provided a regular sense check on how staff were feeling. The data from the national survey and the quarterly pulse check surveys were presented through quarterly dashboards for each care organisation. This identified the direction of travel against nine enablers of staff engagement in addition, allowed the leadership teams to monitor progress and realign targets as necessary. The action plan showed most actions were either completed or on target.

**NHS Staff Survey 2016²**

- The trust has 18 key findings below the average for similar trusts in the 2016 NHS Staff Survey. No findings were better than the England average.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of appraisals</td>
<td>2.89</td>
<td>3.1</td>
</tr>
<tr>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.29</td>
<td>3.45</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.24</td>
<td>3.32</td>
</tr>
<tr>
<td>Effective team working</td>
<td>3.66</td>
<td>3.75</td>
</tr>
<tr>
<td>Support from immediate managers</td>
<td>3.61</td>
<td>3.73</td>
</tr>
<tr>
<td>Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.55</td>
<td>3.72</td>
</tr>
<tr>
<td>Effective use of patient / service user feedback</td>
<td>3.52</td>
<td>3.7</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.38</td>
<td>3.6</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>48.2%</td>
<td>50.5%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.51</td>
<td>3.66</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>27%</td>
<td>25%</td>
</tr>
</tbody>
</table>

² NHS Staff Survey 2016
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell | 61% | 55%
---|---|---
Percentage of staff reporting good communication between senior management and staff | 25% | 33%
Percentage of staff able to contribute towards improvements at work | 66% | 70%
Staff recommendation of the trust as a place to work or receive treatment | 3.45 | 3.77
Percentage believing that trust provides equal opportunities for career progression or promotion | 82% | 86%
Overall Engagement Score | 3.64 | 3.81

**NHS Staff Survey 2016 – Performance on questions relating to harassment, bullying and equal opportunities**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard. Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
<th>Trust 2016</th>
<th>Average (median) for acute trusts</th>
<th>Trust 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td>White</td>
<td>BME</td>
<td>Trust 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30%</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td>White</td>
<td>BME</td>
<td>Trust 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27%</td>
<td>28%</td>
<td>24%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td>White</td>
<td>BME</td>
<td>Trust 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>84%</td>
<td>64%</td>
<td>88%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White</td>
<td>BME</td>
<td>Trust 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6%</td>
<td>17%</td>
<td>6%</td>
</tr>
</tbody>
</table>

The responses from BME and white staff at the trust were significantly different for KF25, KF21 and Q17b and the total response rate was lower than the minimum recommended response rate of 50%. We reviewed the trust’s implementation of the Workforce Race Equality Standard (WRES) and its approach to equality and diversity. The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation. The trust had a published document for WRES with an action plan in place. The action plan linked to the trust’s equality objectives.

The ethnic breakdown of staff did not reflect the local communities it served, however, the trust was introducing a target for BME representation at Band 8 and above, to address the disproportional representation of BME staff and developing a leadership programme for band 5-7 for BME staff. The Chief Executive was the lead sponsor, with Executive Directors mentoring BME staff.

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NHS Staff Survey 2016
Staff diversity

- As of November 2016, the trust employed 8,326.56 WTEs of which 77.7% are women.

Breakdown of staff gender across site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Female</th>
<th>Male</th>
<th>Percentage of workforce</th>
<th>Percentage of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE</td>
<td></td>
<td>WTE</td>
<td></td>
</tr>
<tr>
<td>The Royal Oldham</td>
<td>2293</td>
<td>671.85</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>North Manchester</td>
<td>2376.20</td>
<td>748.90</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairfield General</td>
<td>988.41</td>
<td>300.46</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>Rochdale Infirmary</td>
<td>816.02</td>
<td>131.71</td>
<td>86%</td>
<td>14%</td>
</tr>
</tbody>
</table>

- The ethnic origin of the workforce is predominantly White British, accounting for 80.2% and employees with an Asian background making up 9% of the workforce. The largest proportion of staff at the trust fall into either the 46-50 age range (15.6%) or the 51 – 55 age range (15.9%).

Sickness rates

The trust’s sickness levels from June 2016 to April 2017 were similar to the England average, with rates increasing in line with the England average over the winter period and falling again in 2017, albeit not as low as the England average.

Sickness absence was monitored. The care organisation director team held weekly sickness absence meetings. In most areas, sickness percentages had reduced or were on trajectory for reduction.

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4 RPIR – Universal, submission P104 Care Organisation Stock Take
5 Source: NHS Digital
Management of risk, issues and performance

The Board were aware of the challenges in the organisation to ensure quality of care and patient safety.

The trust worked with internal and external stakeholders to improve the quality of services. This was through a series of improvement projects covering, fragile services, safety, operations and performance, risks and governance, workforce and leadership. The initial phase during 2016/17 was to achieve stabilisation with transformation taking place during 2017/2018. There was a Transformation and Stabilisation Plan with funding of £26m for service improvement for this year and last year.

Governance frameworks were being established, but this was work in progress. We were assured there was a ‘line of sight’, but there remained variation of managing risk and performance frameworks across the care organisations. However, given the challenges identified from the previous inspection, this would take time.

The trust had introduced systems to identify learning from incidents, complaints and safeguarding alerts and make improvements. The system for the management of incidents had improved since the last inspection although it was not fully established in some services. There was no backlog of incidents waiting for investigation in maternity, which was an improvement since the last inspection. There was learning from incidents in each care organisation, however, systems for sharing information for learning across hospital sites was less effective.

We looked at 10 serious incident investigations completed during 2016/17. Most were of a reasonable standard and contained appropriate information. However, the recording of timescales and updating of action plans was variable. The chief nurse told us no serious incident investigation would be closed until the care organisations signed off all actions. The backlog of serious incident investigations identified at the last inspection had reduced.

The trust demonstrated it was prepared to learn from the death of patients and support families and carers through any investigation process. The national guidance on learning from deaths made 12 recommendations for NHS boards. A paper to the trust executive Clinical Effectiveness Committee in October 2017 on the trust position in relation to national guidance on learning from deaths, showed the trust was compliant with 11 of the recommendations. The trust acknowledged that further improvement was needed and this was identified in the Mortality Improvement Plan at trust and care organisation level.

The Chief Medical Officer was the board level leader responsible for Learning from Death agenda and a non-executive lead was responsible to oversee progress. Mortality review was included in the mortality reduction plan and was overseen by the Mortality Surveillance Group and Clinical Effectiveness Committee. There were mortality and morbidity meetings at directorate level. The cases of all patients that had died were reviewed by the speciality and a provisional avoidability score was assigned. Reviews were multi-disciplinary and not conducted by a single doctor and not led by a doctor closely involved in the case. Cases assessed as more serious than “slight evidence of avoidability” were escalated for a second review by the independent corporate team.

A separate programme of independent mortality reviews complemented the speciality reviews to provide additional assurance. Deaths of patients with a learning disability or mental health need were included in the monthly mortality case reviews and examined externally. Patients' relatives were invited to be involved in any investigation to the extent they wish to be. A ‘Learning from Deaths’ report went to the Board.

Each care organisation completed a quality dashboard, which tracked performance against key areas aligned to the trust’s annual plan and quality improvement strategy. The Quality and Patient Experience Assurance Committee reviewed these metrics.
There was an effective governance structure within the pharmacy team, with clear lines of accountability. The Drug and Therapeutics Committee was responsible for maintaining and improving the safe, effective, high quality and cost-effective use of medicines throughout the trust. This was chaired by the deputy medical director and reported to the trust Executive Clinical Effectiveness Committee. The Medicines Safety Officer role was well embedded and there were clear lines of escalation through the trust governance structures for incidents involving medicines.

There was an Annual Infection Prevention and Control report. This demonstrated progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provided assurance to the Infection Prevention and Control Committee and Committees in Common, by monitoring the activity of infection prevention and control and identifying key issues. A Director of Infection Control was aligned to each care organisation. The Chief Medical Officer received monitoring reports and attended root cause analysis reviews for cases of infection. Learning was shared with clinical staff. The trust acknowledged that the environment on some of the hospital sites was challenging. There was an infection control audit completed for each site; this would inform plans for the future development of the estate.

One of the key areas for the trust was the identification and management of sepsis, which had been identified in an independent mortality review as one of the top five causes of death since April 2016. The Chief Medical Officer told us there was a sepsis steering group and a sepsis clinical lead for each care organisation. Care organisations completed a sepsis report for mortality and morbidity meetings. The trust was continuing to work on the trust collaborative on the deteriorating patient and the National Early Warning Score was recently implemented trust wide. Monitoring and assurance was through the harm free care reports reported to the Clinical Effectiveness Committee.

The chief nurse was the executive lead for safeguarding adults and children. The Committees in Common received an annual safeguarding report and a quarterly report was presented at the Performance and Quality Assurance Group. The trust had strengthened its safeguarding function with an associate director for safeguarding and three extra funded nursing posts. The safeguarding team worked closely with the Local Safeguarding Adults and Children Boards and internal policies reflected the appropriate safeguarding legislation and guidance.

Staffing remained a significant risk, but there had been investment in staffing across professional groups and re-basing of ward establishments. Recruitment was challenging, but there were recruitment strategies in place. A staffing acuity system, which measured the care needs of patients by the hour, was being implemented by the summer of 2018. Appraisals performance was reported to the Executive Workforce and Organisational Development Governance Committee, which reported to the Executive Assurance and Risk Committee.

Infrastructures and governance processes for allied healthcare staff were evolving. There was a monthly governance report, which looked at themes from incidents and complaints. This was discussed at cross-site managers meetings and shared with staff. A case review was presented each month to discuss what could be done differently, however, it was not clear how risks were being escalated ‘upwards’. Work was continuing in care organisations to establish reporting mechanisms.

There was a quality impact assessment process. Following the introduction of care organisations and specifically for the 2017/18 Cost Improvement Programme all project initiation documents and quality impact assessments were signed off by the medical and nurse director for each care organisation. If the schemes were trust wide signatures were requested from all care organisation nurse and medical directors. From the 1 November 2017, the assurance process for cost improvement programmes became a group function and the Pennine Acute Hospitals NHS Trust programme has transitioned to the Salford Royal NHS Foundation Trust process. In addition, if
the project initiation document impacts across all four care organisations the Chief Medical Director and Chief Nurse sign the quality impact assessment.

A process for introducing a new surgical procedure or technique into the operating theatre was in place. This meant that any change in products and procedures were evidence based and quality outcomes, risks and training needs identified. The approval process was through the surgical divisional governance process, Drugs and Therapeutic Committee and supplies department.

**Finances overview**

In 2016/17, the trust delivered a deficit position of £2.0m in comparison to a deficit control total of £15.2m. This was an improvement of £13.2m. Within the plan, the trust received £9.2m non-recurrent support from its local clinical commissioning groups and Greater Manchester Health & Social Care economy to support an investment programme to improve the safety and quality of its services and in particular, those areas identified as fragile in the CQC review.

In addition, the £10m improvement in the trust’s cash position, because of the reduced deficit position in 2016/17, was being utilised as part of the trust’s capital programme to improve the estate on the North Manchester and Royal Oldham Hospital sites and work had commenced.

As part of the 2017/18 contract negotiations with the North East Sector clinical commissioning groups, the Trust received further support of £16.4m towards ensuring fragile services were improved and has started to make recurrent investments across a number of service areas, including maternity, paediatrics, critical care, emergency medicine and acute ward staffing.

<table>
<thead>
<tr>
<th>HISTORICAL DATA</th>
<th>PROJECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Metrics</td>
<td>Previous Financial Year</td>
</tr>
<tr>
<td></td>
<td>(2 years ago) (£’000)</td>
</tr>
<tr>
<td>Income (deficit)</td>
<td>No data provided</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>No data provided</td>
</tr>
<tr>
<td>Full costs (deficit)</td>
<td>(611,492)</td>
</tr>
<tr>
<td>Budget (deficit)</td>
<td>(611,512)</td>
</tr>
</tbody>
</table>

**Provider Level risk register**

The service had systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.

The Committees in Common had established a Single Oversight Framework (the framework helps support NHS providers to give patients safe care in local health systems that are financially and clinically sustainable). The trust’s care organisations chief officers submitted a monthly statement of assurance supported by a quarterly presentation of each care organisation’s key risks to the Group Executive Risk Assurance Committee.

The Board of Directors reviewed the Corporate Risk Register at the start of the year. It contained all principal risks to the delivery of Annual Plan objectives. Other risks to delivery identified within the organisation scored 12 and above were included within the Board Assurance Framework. The Chief Executive provided the leadership to the risk management process. This responsibility

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6 RPIR – Universal – Finances tab
included consideration of the trusts risk register and resource allocation to the significant risks of the trust.

We reviewed divisional and care organisation risk registers. The risks detailed were reflective of those highlighted to us by frontline staff and directorate leads and broadly correlated with our findings during the inspection.

The trust have provided one document listed as their Board Assurance Framework/Corporate Risk Register, which details 40 risks and the action plans regarding review and management of them. (See section below for details)

**Board Assurance Framework**

- The trust have provided their Board Assurance Framework/Corporate Risk Register, which for 2017/18 contains 40 risks and gaps in the risk controls, which impact upon strategic ambitions.

- The six strategic ambitions outlined by the trust are as follows:

  1. Pursuing Quality Improvement to assure safe, reliable and compassionate care (12 risks)
  2. Deliver Financial Plan to assure sustainability (one risk)
  3. Support our staff to deliver high performance and improvement (four risks)
  4. Improving care and services through Integration and Collaboration (six risks)
  5. Delivery of mandatory standards (13 risks)
  6. Implement Enabling strategies (four risks)

- There are 21 key risks scoring 12 and above on the Board Assurance Framework/Corporate Risk Register.

- A score of 12 and above is defined by the trust as “a significant serious risk to the trust, which must be reported to and managed through the Board of Directors via EARC (Executive Assurance and Risk Committee)".

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Risk Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Stabilising the workforce in ED and AMU</td>
</tr>
<tr>
<td>13</td>
<td>Recruiting to establishment</td>
</tr>
<tr>
<td>13</td>
<td>Achieving the 62 day national cancer target</td>
</tr>
<tr>
<td>13</td>
<td>Learning Lessons from the Diagnostic Review</td>
</tr>
<tr>
<td>13</td>
<td>Clinisys Lab Systems</td>
</tr>
<tr>
<td>12</td>
<td>Caring for the deteriorating patient</td>
</tr>
<tr>
<td>12</td>
<td>Caring for patients with sepsis</td>
</tr>
<tr>
<td>12</td>
<td>Learning Lessons</td>
</tr>
<tr>
<td>12</td>
<td>Delivering an effective Quality Improvement Strategy</td>
</tr>
<tr>
<td>12</td>
<td>Delivering the Cost Improvement Programme Target</td>
</tr>
<tr>
<td>12</td>
<td>Putting clinical leadership in place</td>
</tr>
<tr>
<td>12</td>
<td>Regaining JAG accreditation</td>
</tr>
<tr>
<td>12</td>
<td>Achieving planned activity and income levels</td>
</tr>
<tr>
<td>12</td>
<td>Retrieving clinical notes electronically (Evolve)</td>
</tr>
<tr>
<td>12</td>
<td>Cyber security threat</td>
</tr>
<tr>
<td>12</td>
<td>Improving patient flow</td>
</tr>
</tbody>
</table>

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7 RPIR – Universal – submission P112 PAT BAF July
Information management

The Information Technology (IT) infrastructure was very poor and posed potential clinical risks. There were many systems patched together, resulting in very slow systems affecting service delivery. An example was the delays in scanning of notes after each admission, which affect if patients were re-admitted during this time. Access to test results particularly in outpatients was very slow. The poor IT infrastructure resulted in ‘work rounds’ and again posed potential clinical risks and inefficient working practices. The trust acknowledged that the reliability and validity of data quality was a challenge. There was an action plan and progress was being made against each of the measures.

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. The trust had completed the information governance toolkit assessment, which described how the trust saw its management and security of information. The trust assessed itself on measures of assurance, including confidentiality and security of records, the quality of information, the secondary use of information, and a measure for the overall performance. The trust achieved the required level across all standards of the Information Governance Toolkit. External auditors confirmed a significant assurance rating for the evidence submitted. However, during our unannounced inspection at Fairfield emergency department, we found a number of computer screens showing information about patients in areas accessible to the public. We brought this to the attention of the clinical leader, who took immediate action.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported to the NHS national reporting and learning system or the NHS strategic executive information system.

The trust had not been affected by the NHS wide cyber-attack in 2017. The trust managed security alerts and a Cyber Security assessment had been completed. There was further work to implement the national guidance of 10 steps to cyber security; this was identified as a risk on the trust’s Board Assurance Framework. The Caldicott and Information Governance Group monitored action plans and reported to the Finance and Information Committee, escalating risks to the Committees in Common as required.

Engagement

The trust was developing a structured and systematic approach to engaging with people who use services, those close to them and their representatives. There was a Patient Experience Strategy, which set out objectives for working together with patients, carers and the public, to ensure feedback from experience was used to improve patient care. The strategy was being updated to reflect the trust objectives and reorganisation. There was no date yet for consultation.

During 2016/17, several age appropriate initiatives and local surveys were completed to gain patient experience feedback, in order to improve care and services for children and young people. This included the use of the 'Tops and Pants' programme in both the children’s inpatient and outpatient areas. This enabled the 'voice of the child' to be heard and acted upon to initiate improvements and identify and share good practice. The trust employed a range of methods, including engaging school age children, in developing surveys to ensure engagement of children and young people in the development of services.
The Patient Experience team was working with the Greater Manchester Cancer Vanguard team in a pilot facilitated by ‘I want great care’ to gain real time patient experience regarding key indicators. This included public awareness of cancer at point of referral, awareness of clinical trials, patient access to 24/7 specialist care and palliative care, feedback on the handover between clinicians and self-managed care.

The trust completed a medical engagement survey using a national programme: ‘Enhancing Engagement in Medical Leadership’. Three hundred and ninety-two medical staff completed the survey. The overall level of medical engagement fell within the medium engagement band. The climate for positive learning and appraisal and rewards were rated within the high-level engagement band. Data showed that consultants were positively engaged on seven of the ten scales and moderately engaged in three. Profiles for non-consultant medical staff were ‘mixed.’

At care organisation level, the results showed moderate to positive engagement levels. At North Manchester, the average rating for good interpersonal relationships was less positive. Levels within divisions ranged from moderate to strongly positive, however, in the division of surgery, nine out of 10 scales were either low or lowest engagement bands. We held consultant focus groups in each of the care organisations and although attendance was low, most consultants we spoke with felt more positive about the changes in the trust.

A staff engagement report (May 2017) recommended the ‘Go Engage’ model of working to improve staff engagement in each care organisation. This combined evidence-based interventions aligned to strategic priorities for improvement identified by staff. There was a staff engagement lead. The trust measured staff engagement on a quarterly basis. Care organisations used a staff engagement dashboard to monitor results.

Staff were encouraged to make suggestions for improvement and gave examples of ideas they had implemented. ‘Go Engage’ Pioneer teams involved staff to deliver improvements. Examples included changes to patient transfers to theatre, thus improving patient flow, more efficient storage, labelling of orthopaedic prosthesis and providing a better environment for a relative’s room on ward I-5 at North Manchester General Hospital.

The trust had introduced ‘1000 Voices’ engagement events within each care organisation, aligned with executive ‘work withs’ (executive directors working on wards and service areas), walk arounds and igniting ‘Pride in Pennine’ (motivational days for staff). However, discussions with front line staff during the core service inspection and in focus groups drew mixed comments about executive leaders’ visibility.

A nursing leadership board with representation from nursing, midwifery and allied health care professionals was being developed. The Directors of Nursing met with ward managers each month. Pharmacy staff were actively engaged in discussions about service performance and development at weekly departmental meetings, however, these were not formally minuted.

The trust was developing stronger relationships with external stakeholders. The Clinical Commissioning Groups reported that engagement and transparency had improved at a corporate level. The trust communication team was looking to develop tailored communication and engagement methods for each locality, Clinical Commissioning Groups and Local Authority to focus on local issues, performance, service improvements and strategic plans.

Learning, continuous improvement and innovation

Complaints process overview

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8 RPIR – Universal – Complaints overview tab
The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>What is your internal target for responding to complaints?</th>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for completing a complaint</td>
<td>3 working days</td>
<td>93% (March 17)</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>25 working days</td>
<td>25% (March 17)</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months</td>
<td>60 working days for high risk complaints</td>
<td>25% (March 17)</td>
</tr>
</tbody>
</table>

Complaints

- The trust received 814 complaints between June 2016 and May 2017.
- Surgery received the most complaints with 257 (32% of all complaints).
- The average number of working days taken to close complaints ranged from 44 (other) to 98 (critical care) days.
- The 25 working day complaints target was not met for any of the core services below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Proportion of total</th>
<th>Average of Number of days to close</th>
<th>Trust target for dealing with complaints (days)</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>257</td>
<td>31.57%</td>
<td>64</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Medicine</td>
<td>166</td>
<td>20.39%</td>
<td>64</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>149</td>
<td>18.30%</td>
<td>63</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>88</td>
<td>10.81%</td>
<td>44</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Maternity</td>
<td>45</td>
<td>5.53%</td>
<td>65</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Community</td>
<td>36</td>
<td>4.42%</td>
<td>56</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>32</td>
<td>3.93%</td>
<td>67</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Children</td>
<td>22</td>
<td>2.70%</td>
<td>68</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>OPD</td>
<td>14</td>
<td>1.72%</td>
<td>59</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Critical Care</td>
<td>5</td>
<td>0.61%</td>
<td>98</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>814</td>
<td>31.57%</td>
<td>64</td>
<td>25</td>
<td>No</td>
</tr>
</tbody>
</table>

We looked at 10 complaints. In four cases, the acknowledgement letter had breached three working days. In five complaints, the response had taken longer than 60 working days to complete. In most cases, responses were of sufficient quality.

There was sufficient staff in the complaints team. The team was aware of the priorities to reduce the backlog of complaints. At the time of inspection, there were no complaints over 100 days. Temporary support was given to divisions where the numbers of complaints and backlog were highest. The Clinical Commissioning Group had set a target to ensure 90% compliance by

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9 RPIR – Universal – Complaints tab
January 2018 in meeting complaint response times. Data for July 2017 showed the trust was 47% compliant against this target.

The trust-monitored complaints through the divisional and trust governance processes and reported to the Executive Quality and Patient Experience Governance Committee and to the Board of Directors on an exception basis. A complaints annual report was presented to the Board. Complaints were tracked using one system in the trust and data presented weekly to the divisional senior management teams.

Themes from complaints were joined with incidents and other quality metrics, so that services could use complaints as a quality measure for improvement and as a measure of where significant improvements may need to be made. Learning from complaints was included in safety huddles and ward meetings over seven days. This ensured information was communicated to staff on each shift. There is a weekly serious incident review meeting which includes complaints that have been declared serious incidents. This meeting is chaired by the Director of Patient Safety. There is no Complaints Quality Assurance Group, however in January 2018 the trust commenced a Complaints Review Panel chaired by a non-executive director this was only planned to be put in place at the inspection. The Director of Governance and Corporate Nursing presents the trust position on complaints and themes, trends and learning to the Executive Quality and Patient Experience Governance Committee.

The trust closed 26 cases investigated by the Parliamentary Health Service Ombudsman between 1 June 2016 and 31 May 2017. Seventeen of these were not upheld, one was referred back for local resolution, one was fully upheld and seven partially upheld. Although there have been no actions taken as a direct result of the investigations, action was taken during the period from when the complaint was received and the Parliamentary Health Service Ombudsman became involved. This included review of ‘Do Not Attempt Cardio Pulmonary Resuscitation’ systems, falls prevention and the introduction of safety huddles three times a day.

The trust had introduced the Nursing Assessment and Accreditation System, which is used at Salford Royal Hospital. This is a nationally recognised assessment tool designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. The wards are assessed using a rating of red (level 0) amber (level 1), green (level 2) and blue (level 3). The October 2017 data for all hospital sites showed 26% of wards were red, 48% amber and 26% green.

The work of the newly appointed Falls Prevention Team supported the trust in reducing the number of reported falls incidents by 15% over the last 12 months. Bay Tagging had been introduced on the wards as part of the Enhanced Observation Policy; these processes enabled nursing staff to monitor patients within the bays, to be able to anticipate patients’ needs and support them to minimise the risk of falling.

The safeguarding team provided staff with a ‘virtual toolbox’ to support them care and manage patients with cognitive impairment; this model focused on specific wards for a month to provide all staff with knowledge and skills required to promote a team approach to changing practice and attitude.

There was a pathway for people with learning disabilities and autism based on best practice guidance. A learning disability liaison nurse provided support and developed hospital and community systems, influencing strategies and policies and educating hospital staff.

The trust used the NHS Premises Assurance Model. The model is used to confirm that systems are in place to assure that premises and associated services are safe. The assurance model was linked to trust risk registers. There were four separate estates strategies for each care organisation and a plan to put in an estates general manager for each site. The trust
acknowledged that some of the estate was not fit for purpose. £10m was being utilised as part of the trust’s capital programme to improve the estate on the North Manchester and Royal Oldham Hospital sites and work had commenced.

There were a number of innovative programmes involving the pharmacy team. These included medicines management pharmacy assistants to support technicians and pharmacists at ward level. In addition, there were technician-assisted medicines rounds. Data showed a reduction in delayed and omitted doses and a reduction in medicines being unavailable as a result.

**Accreditations**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. The table below shows which services within the trust have been awarded an accreditation, together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Details of accreditation and date (if available)</th>
<th>Related core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology</td>
<td>Haematology &amp; Blood Transfusion: ISO 15189 accredited since 30/11/2015 (last surveillance visit 10/05/2017)</td>
<td>Diagnostic imaging</td>
</tr>
<tr>
<td>Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Microbiology: currently CPA accredited (last visited 10/12/2013) awaiting confirmation of ISO 15189 accreditation following assessment visit 13/09/2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Biochemistry: currently CPA accredited (last visited 16/02/2015) ISO 15189 assessment visit pending</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cellular Pathology: currently CPA accredited (last visited 7/05/2015) ISO 15189 assessment visit pending</td>
<td></td>
</tr>
</tbody>
</table>

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10 RPIR – Universal – Accreditation tab
North Manchester General Hospital

Urgent and emergency care

Facts and data about this service

The trust provides urgent and accident and emergency services at the Royal Oldham Hospital, North Manchester General Hospital, Fairfield General Hospital and from an urgent care centre at Rochdale Infirmary. We did not inspect the urgent care centre during this inspection visit.

The accident and emergency department at the North Manchester General Hospital provides a 24 hour, seven day a week service to the local population. Between November 2016 to October 2017, there were 99,746 accident and emergency department attendances at North Manchester General Hospital. This equates to an average of 274 patients a day.

The accident and emergency department at North Manchester General Hospital is not a designated trauma unit, but it does receive self-presenting trauma patients. More severely injured patients would routinely be taken by ambulance to their nearest major trauma centre, but if a patient self-presented at North Manchester General Hospital, they would be stabilised and staff would follow a protocol to decide which patients they could treat or which patients would have to transfer.

The accident and emergency department has five resuscitation bays, two of which are specially equipped for children. There are 13 cubicles to treat patients with major injuries and illnesses, six trolley spaces and seven bed spaces to treat minor injuries, a room used for patients presenting with mental ill-health, two bays for rapid assessment and two separate triage rooms. The department has a separate prisoner and police custody room for the use of prisoners from the nearby prison or patients brought in with a police escort. In the paediatric accident and emergency department there are five cubicles, a designated room used for infection control and high risk patients, a designated high care area, a bespoke sensory room, a triage room and a separate reception and waiting area.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. The department provides a GP streaming service on triage; patients who are deemed suitable will see a GP in the department, rather than one of the accident and emergency doctors.

We inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with 11 patients and carers and 17 staff from different disciplines. We observed daily practice and viewed seven sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Is the service safe?

Mandatory training

Mandatory training was available to all staff to enable them to provide safe care and treatment to patients. Mandatory training was delivered in a blended approach, which included e-learning and classroom sessions.

Mandatory training included induction, workplace induction, fire awareness, hand washing, information governance, infection prevention, moving and handling, waste management, equality and human rights, health and safety and adults and children’s safeguarding.
We saw evidence of a live training monitoring tool that detailed which staff had completed mandatory training. The clinical nurse practice educator was responsible for monitoring training completion rates. They told us that when staff were due to renew their training, they were reminded and booked on the next course.

The training monitoring tool showed nursing staff were up to date with their mandatory training in all areas.

There was a sepsis pathway and staff were aware of how to manage a patient with sepsis as they received in-house sepsis training. At the time of our inspection 96% of staff had completed the sepsis training. There was a built in sepsis screening tool as part of the patient observation chart.

**Life support training rates – nursing staff North Manchester General Hospital:**

<table>
<thead>
<tr>
<th>Course</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Adult Life Support</td>
<td>86%</td>
</tr>
<tr>
<td>Basic Paediatric Life Support</td>
<td>78%</td>
</tr>
<tr>
<td>Advanced Life Support</td>
<td>68%</td>
</tr>
<tr>
<td>Advanced Paediatric Life Support</td>
<td>67%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>67%</td>
</tr>
<tr>
<td>Immediate Paediatric Life Support</td>
<td>45%</td>
</tr>
</tbody>
</table>

(Source: Data request DR88 DR99 compliance report all sites)

**Mandatory training completion rates**

The trust set a target of 90% completion of mandatory training. At the time of our inspection we saw that nursing staff were up to date with their mandatory training with a compliance rate of 97%.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in Urgent and Emergency Care are shown below:
Medical and dental staff working in Urgent and Emergency Care failed to meet the 90% target for mandatory compliance for all 16 modules.

Paediatric basic life support and basic life support training had the lowest compliance levels with only 37% and 51% of eligible medical and dental staff having been trained.

Nursing and midwifery staff working in Urgent and Emergency Care met the 90% target for mandatory training compliance in three modules (equality and human rights tier 2, hand hygiene assessment and information governance).

Immediate life support and paediatric immediate life support training had the lowest compliance levels with only 33% and 48% of eligible nursing and midwifery staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

The accident and emergency department had a clear system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence). The department had two safeguarding quality champions (link nurses), one in paediatrics and one in adults. The safeguarding policy was available on the trust intranet.

Staff told us that children with a previous safeguarding referral or who are well known to the service are flagged up on triage with a hashtag next to their name. This enables the staff to identify that there has been previous safeguarding involvement or concerns. A nurse we spoke with told us they were confident that they could raise a concern, even if medical staff did not share the concern; they would then escalate to the internal safeguarding team and complete a section 17 or section 47 referral depending on the situation.

Safeguarding referrals were completed electronically via the trust intranet, which submitted them directly to the internal safeguarding team, who reviewed and sent them to the relevant local authorities.

Staff we spoke with told us that safeguarding was ‘everyone’s responsibility’ and they knew that there was a policy and internal safeguarding team they could access. However, not all staff were aware of who was the trust safeguarding lead was or who the department’s safeguarding quality champions (link nurses) were.
Staff were aware of other safeguarding issues such as child sexual exploitation, female genital mutilation (FGM) and adults and children at risk of radicalisation and there were proformas to complete.

### Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. At the time of our inspection in October 2017, 97% of the nursing staff in the accident and emergency department had completed their safeguarding adults level 2 training and safeguarding children level 2 training.

We saw that 86% of nursing staff across both the adult and paediatric accident and emergency departments were trained in level 3 children’s safeguarding and 85% of nursing staff were trained in level 3 adults safeguarding, which was still slightly below the trust target of 90%; however those waiting for the training had been booked on to upcoming sessions. We did not see updated level 3 training data for medical staff in the department.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in Urgent and Emergency Care is show below:

NB – data from the following teams have been used for the below as the trust did not include a specific Urgent and Emergency Care core service for the training data supplied in the RPIR:

- BD215 - Medical Staff - UCC (Rochdale), BD311 - Urgent Care Centre (Rochdale), BE404 - Urgent Care Teams, CB100 - Urgent Care Mgmt (Bury), CB101 - Urgent Care Mgmt (North), CB102 - Urgent Care Mgmt (Oldham), BD305 - Urgent Care Teams, CB309 - Accident & Emergency (Oldham), CB307 - Accident & Emergency (North), CB309 - Accident & Emergency (Oldham), CB322 - A&E - ENPs (North), CB324 - A&E - ENPs (Oldham), CSPR - Accident and Emergency (SPRs)

![Safeguarding Training Completion by module](image)

Medical and dental staff working in Urgent and Emergency Care at the trust didn't meet the 90% target for any of the safeguarding modules. Level 2 adults and children both had 85% compliance with 74 of the 87 eligible staff members completing the training in both these modules.

Compliance for level 3 adults was the lowest, with only 44% of eligible staff members completing the training.
Nursing and midwifery staff working in Urgent and Emergency Care at the trust exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The accident and emergency department appeared clean, tidy and uncluttered. Cleaning services were provided by an external cleaning partner. Four domestic staff worked in the department to provide cleaning services during the day. The matron told us they had a good working relationship with the cleaning supervisor, who did regular audits and unannounced inspections to ensure standards were maintained. In a recent cleaning audit the department had scored 100% for nursing and 91.6% for domestic facilities. The department’s domestic staff did not routinely work nights, so overnight cleaning could be organised via the rapid response line.

Staff completed core training related to their roles, the trust set a 90% completion rate for the following training: handwashing (100% complete), infection prevention for patient handlers (96% complete), infection prevention for non-patient handlers (100% complete), clinical waste segregation (97% complete) and waste management (100% complete).

The accident and emergency department completed hand hygiene audits. We observed that the most recent hand hygiene audit results were displayed on the ‘open and honest’ board and were at 94%.

Staff adhered to the infection control policy and used personal protective equipment when delivering personal care. We observed medical and nursing staff following the trust policy for hand washing and ‘arms bare below the elbows’ guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle, on the corridors and next to the doors.

Green ‘I’m clean’ labels were in use throughout the department and were dated appropriately. Patients we spoke with were happy with the cleanliness and appearance of the department.

There had never been an instance of meticillin-resistant staphylococcus aureus on the accident and emergency department and these results were displayed on the ‘open and honest’ board.
Staff used the appropriate coloured bags to segregate waste and the domestic staff removed waste from the accident and emergency department. Large red bins were in use for confidential waste and we saw these in use in the department.

**Environment and equipment**

All doors were unobstructed and fire escapes were clear. In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to be sufficient seating in the adult accident and emergency department. However, when the paediatric accident and emergency department was busy, there was not enough seating to accommodate all those waiting to be seen.

The adult waiting area had separate male, female and disabled toilets. We identified a potential ligature point in the male toilet and this was escalated by a member of staff and estates immediately removed it. The other toilets were all safe and ligature point free. Each toilet had a panic button or pull cord to alert staff if help was needed.

The paediatric accident and emergency department had a separate waiting area and reception, completely separated from the adult area by double doors. However, the waiting room was not directly in the line of sight of the receptionist, as it was located around the corner. There were separate male and female toilets and a disabled toilet self-contained within the paediatric department.

There was a set of fire escape doors at the bottom end of the adult accident and emergency minors department; we asked if there was the possibility of absconders (particularly patients with head injuries or dementia) accessing these doors if staff were busy elsewhere in the department. We were told this had not happened before, but the department had risk assessed and recognised the risk. We were told that patients with dementia were accommodated in this area.

The accident and emergency department was close to car parks and had a drop off area for police and ambulances.

Panic alarms and call bells were tested daily as part of the daily checklist. Staff told us that the panic alarms sounded with a different alarm than the call bells so staff could easily differentiate between the two.

Emergency trolleys were checked daily and equipment trolleys were clearly labelled. There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date. Resuscitation bays were well equipped, the paediatric bay had paediatric specific instructions on a whiteboard. The Glasgow coma scale was displayed in both adult and paediatric bays.

Storerooms were well organised and had good processes for stock rotation. Sluice/utility rooms had locked doors and were well organised.

Equipment we reviewed had been safety tested and the next test date was recorded (March 2018).

Sharps bins were not overly full and were clearly labelled, however, we observed that not all sharps bins were secure, as one was left open.

We observed a member of staff changing the curtains in the resus bays. They told us that curtains are changed on rotation every three months, but the accident and emergency department had spare curtains if they need to be changed earlier. Curtains were hung and dated with the date they were replaced.

**Assessing and responding to patient risk**

The accident and emergency department had a clear triage and screening process. An advanced nurse practitioner (ANP) carried a sepsis ‘deck’ phone during the day, which was called to alert the
arrival of a patient with suspected sepsis and then the patient would be treated according to the documented sepsis pathway and bundle. During the night, a middle grade doctor would carry the phone. The ambulance service 'red flagged' any patient with suspected sepsis, so the department were aware they were on their way. An experienced nurse was responsible for rapid assessment, of which there were two stretcher bays allocated. Rapid assessment meant that blood tests, cannulation or an ECG could be commenced as soon as the patient arrived in the department. However, rapid assessment was not always staffed if the department was short staffed. When rapid assessment was not staffed, the patient would go straight to the major’s area to commence treatment.

We found staff were able to identify and respond appropriately to patients who were at risk of deteriorating. A national early warning score system for acutely ill patients was used. This supported the process for the early recognition of adult patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. A similar paediatric observation priority scores was used for early recognition of children who were becoming unwell. Staff also told us there was a new project in the pipeline to design and develop a new paediatric early warning score system. Following learning from a serious incident, the department also used maternity modified early warning scores when pregnant patients presented at the department.

We checked seven adults' records and found all bar one had the NEWS scores completed. The patient that did not have them completed had been seen by the GP and did not require an early warning score assessment as the patient attended with a very minor illness / injury..

There were posters up in the department informing patients to alert staff if they had recently undergone chemotherapy. These posters had been created in response to some learning that had been a result of the findings from the departments' Royal College of Emergency Medicine audits in relation to neutropenic sepsis. Neutropenic sepsis is a life threatening complication of anticancer treatment, the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever. There were now more robust processes to identify patients with potential neutropenic sepsis.

**Accident and Emergency Survey**

The trust scored “about the same” as other trusts for all five of the 2014 accident and emergency Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the accident and emergency staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q6. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q7. From the time you first arrived at the accident and emergency department, how long did you wait before being examined by a doctor or nurse?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. In your opinion, how clean was the accident and emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. While you were in the accident and emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC - Accident and Emergency Survey (01/01/2014 - 31/03/2014)

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.
The trust did not meet the standard over the 12 month period between August 2016 and July 2017.

Performance improved from May 2017 onwards where performance was closer to the standard than in previous months during the period. In July 2017 the median time to treatment was 65 minutes compared to the England average of 60 minutes.

At the time of our inspection, further data was available for August 2017 and September 2017. The median time to treatment for the trust in August was 59 minutes compared to the England average of 53 minutes, which met the Royal College of Emergency Medicine recommendations of receiving treatment in no more than one hour. In September the median time to treatment for the trust was 61 minutes compared to the England average of 58 minutes, which did not meet the standard, however was close to it.

### Time to treatment all patients between August 2016 and July 2017 at The Pennine Acute Hospitals NHS Trust

![Graph showing time to treatment for different months.](image)

(Source: NHS DIGITAL: Accident and emergency quality indicators)

### Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median for 11 of the 12 months between August 2016 and July 2017.

In July 2017 the median time to initial assessment was 8 minutes compared to the England average of 7 minutes.

In August 2017 the median time to initial assessment was 7 minutes compared to the England average of 7 minutes.

In September 2017 the median time to initial assessment was 8 minutes compared to the England average of 7 minutes.

(Source: NHS DIGITAL: Accident and emergency quality indicators)

### Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

North Manchester General Hospital
Between September 2016 and August 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at North Manchester General Hospital.

April 2017 to August 2017 has seen a lower proportion of ambulance journeys with turnaround times over 30 minutes compared to September 2016 to March 2017, but has also remained stable.

December 2016 to March 2017 saw the highest number of journeys with turnaround times over 60 minutes during the period.

**Ambulance: Number of journeys with turnaround times over 30 minutes - North Manchester General Hospital**

<table>
<thead>
<tr>
<th>Month</th>
<th>0-30 mins</th>
<th>Over 30 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-16</td>
<td>1200</td>
<td>400</td>
</tr>
<tr>
<td>Oct-16</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Nov-16</td>
<td>600</td>
<td>1200</td>
</tr>
<tr>
<td>Dec-16</td>
<td>400</td>
<td>1200</td>
</tr>
<tr>
<td>Jan-17</td>
<td>200</td>
<td>1200</td>
</tr>
<tr>
<td>Feb-17</td>
<td>100</td>
<td>1200</td>
</tr>
<tr>
<td>Mar-17</td>
<td>0</td>
<td>1200</td>
</tr>
<tr>
<td>Apr-17</td>
<td>0</td>
<td>1200</td>
</tr>
<tr>
<td>May-17</td>
<td>0</td>
<td>1200</td>
</tr>
<tr>
<td>Jun-17</td>
<td>0</td>
<td>1200</td>
</tr>
<tr>
<td>Jul-17</td>
<td>0</td>
<td>1200</td>
</tr>
<tr>
<td>Aug-17</td>
<td>0</td>
<td>1200</td>
</tr>
</tbody>
</table>

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - North Manchester General Hospital**

- Between 30 and 60 minutes: 54%
- Over 60 minutes: 36%
- 0-18 minutes: 18%
- 0%: 0%

(Source: South East Coast Ambulance Service – collated on behalf of North West Ambulance Service - Ambulance Turnaround Times)

The urgent and emergency service collected data on a separate measure of handover times greater than 30 minutes. This was measured from the time of arrival of the patient by ambulance to the service’s acceptance of responsibility for the patient. This showed that, between October 2016 and September 2017, North Manchester recorded a total of 5077 ambulance arrivals with handover greater than 30 minutes or where no timestamp had been recorded. This equated to an average of 20% of ambulance arrivals and 141 cases per month.

**Number of black breaches for this trust**

We do not have the data on black breaches broken down by location; therefore we will report black breaches as a trust wide data source.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

Between 06 June 2016 and 29 May 2017 the trust reported 2890 “black breaches”. The number of black breaches increased from December 2016 to January 2017 where it peaked at 509 breaches. The number of breaches has fallen since January 2017, aside from April 2017 where...
numbers increased again slightly.

![Black breaches per month](image)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

At location level, between October 2016 and September 2017, North Manchester recorded 1224 cases where handover of the patient to hospital staff took longer than 60 minutes which equated to an overall average of 102 per month. The number of black breaches peaked during the winter period with 173 breaches in December 2016 and 169 breaches in January 2017, which was in line with the trend for black breaches across the trust.

**Nurse staffing**

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in Urgent and Emergency care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>250.83</td>
<td>276.24</td>
</tr>
<tr>
<td>January 17</td>
<td>257.39</td>
<td>276.24</td>
</tr>
<tr>
<td>February 17</td>
<td>258.46</td>
<td>276.24</td>
</tr>
<tr>
<td>March 17</td>
<td>269.46</td>
<td>275.24</td>
</tr>
<tr>
<td>April 17</td>
<td>269.60</td>
<td>275.24</td>
</tr>
<tr>
<td>May 17</td>
<td>272.27</td>
<td>283.86</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**North Manchester General Hospital Planned Whole Time Equivalent vs. Actual Whole Time Equivalent Staffing**
At the time of our inspection the trust had recently recruited 14 new nurses to the department, there were further nursing vacancies split over the adult and paediatric department. The rotas were planned to ensure an appropriate skill mix and was in line with the Royal College of Emergency Medicine guidelines. We reviewed staffing and rotas and were assured that the skill mix was appropriate.

The department still had some issues with nurse staffing, during our inspection we noted the planned and actual staffing for the unit:

### 17 October 2017

<table>
<thead>
<tr>
<th>Shift</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>Qualified - 13</td>
<td>Qualified - 12</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 4</td>
<td>Unqualified - 3</td>
</tr>
<tr>
<td>Late</td>
<td>Qualified - 14</td>
<td>Qualified - 13</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 4</td>
<td>Unqualified - 3</td>
</tr>
<tr>
<td>Night</td>
<td>Qualified - 13</td>
<td>Qualified - 13</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 3</td>
<td>Unqualified - 4</td>
</tr>
</tbody>
</table>

### 19 October 2017

<table>
<thead>
<tr>
<th>Shift</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>Qualified - 13</td>
<td>Qualified -12</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 4</td>
<td>Unqualified - 2</td>
</tr>
<tr>
<td>Late</td>
<td>Qualified - 14</td>
<td>Qualified - 11</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 4</td>
<td>Unqualified - 2</td>
</tr>
<tr>
<td>Night</td>
<td>Qualified - 13</td>
<td>Qualified - 12</td>
</tr>
<tr>
<td></td>
<td>Unqualified - 3</td>
<td>Unqualified - 3</td>
</tr>
</tbody>
</table>

Managers acknowledged that staffing had historically been a challenge, but there were improvements and new staff was being recruited. No one we spoke with felt that staffing was unsafe or a risk to patient safety. If the accident and emergency department was short on nursing staff, areas such as the rapid assessment would not be staffed.

Staffing was planned on an electronic system by senior staff in the accident and emergency department. The department rostered for full staffing and moved staff around the department depending on acuity.

Agency and bank staff were used to fill vacant shifts where possible. The paediatric accident and emergency department were paying bank staff at an enhanced rate to fill vacant shifts with experienced internal staff.

Nurse staffing was over three shifts: early, late and night shifts. We reviewed a sample of the rotas and we were satisfied that staffing was well planned and at safe levels.

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 6.8% for
nursing and midwifery staff in urgent and emergency care;
- North Manchester General Hospital: 9%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**
Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing and midwifery staff in urgent and emergency care;
- North Manchester General Hospital: 1.1%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
Between June 2016 and May 2017, the trust reported an average sickness rate of 5.2% for nursing and midwifery staff in urgent and emergency care, which is higher than the trust target of 4.6% for sickness rates.

At time of our inspection we reviewed new figures that showed the sickness rate at 3.39% for nursing staff which is below the trust target of 4.6%.
- North Manchester General Hospital: 6.8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Medical staffing**
The trust has reported the following planned and actual staffing figures for medical and dental staff working in urgent and emergency care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>75.54</td>
<td>104.10</td>
</tr>
<tr>
<td>January 17</td>
<td>76.54</td>
<td>104.10</td>
</tr>
<tr>
<td>February 17</td>
<td>75.04</td>
<td>104.10</td>
</tr>
<tr>
<td>March 17</td>
<td>75.96</td>
<td>104.10</td>
</tr>
<tr>
<td>April 17</td>
<td>77.56</td>
<td>104.10</td>
</tr>
<tr>
<td>May 17</td>
<td>77.56</td>
<td>104.10</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

At the time of our inspection, the trust had recently recruited four new consultants.

There was consultant cover in the department between 8am and 10pm on Monday to Friday and 9am and 5pm on Saturday and Sunday. Out of hours there was an on call consultant; this did not meet the Royal College of Emergency Medicine guidance of consultant presence 16 hours a day. A middle grade doctor was available in the department 24 hours a day.

**Vacancy rates**
Between June 2016 and May 2017, the trust reported an average vacancy rate of 26% for medical and dental staff in urgent and emergency care;
- North Manchester General Hospital: 32%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
Between June 2016 and May 2017 the trust reported an average turnover rate of 3.5% for medical staff in urgent and emergency care;

- North Manchester General Hospital: 2.6%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Between June 2016 and May 2017, the trust reported an average sickness rate of 1.5% for medical staff in urgent and emergency care which is better than the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 2.9%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
Between 1st May and 31st October 2017 agency staff filled 963 medical staff shifts as broken down below.

<table>
<thead>
<tr>
<th>North Manchester General Hospital – Total</th>
<th>963</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifts Covered by Locums</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>163</td>
</tr>
<tr>
<td>Specialist Training Year 1</td>
<td>14</td>
</tr>
<tr>
<td>Specialist Training Year 2</td>
<td>466</td>
</tr>
<tr>
<td>Specialist Training Year 3</td>
<td>22</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>298</td>
</tr>
</tbody>
</table>

(Source: Data request DR98 AE shifts covered by locums)

Staffing skill mix
Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 84 whole time equivalent staff working in Urgent and Emergency Care at The Pennine Acute Hospitals NHS Trust.
Records

The accident and emergency department used paper records for patient notes and assessments and an electronic system for tracking lengths of stay and requesting referrals, x-rays and tests.

We reviewed seven sets of patient records. All notes in patient files were signed, dated and legible. Pressure assessments were complete, where applicable, and early warning scores and pain scores were recorded.

A senior consultant and senior nurse undertook ‘quality rounds’ every two hours within the accident and emergency department and every patient and their paperwork were reviewed. This provided a mitigation and quality control in relation to records as any issues identified could be flagged by the senior consultant or senior nurse and rectified.

Discharge summaries were electronically generated and sent to the patients’ GP.

Paper records were archived once the patient was discharged and held in secure storage for a specified period and then disposed of securely in line with trust policy.

Medicines

The service managed medicines well. There was a pharmacist that restocked the accident and emergency department’s medicines and daily checks were undertaken.

Controlled drugs were recorded and stored appropriately; the pharmacist and matron checked the controlled drugs checklist on a weekly basis and both signed to say it had been reviewed, ensuring there was double assurance against the daily checks that had been completed.

We reviewed a sample of medicines and all were stored appropriately and within their expiry date.

Medical gases and fluids were stored appropriately.

Fridge temperatures were monitored and we reviewed up to date lists. Staff told us that if there are any temperature issues identified, they are escalated and actioned by the matron.

A patient group directive (PGD) allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

Incidents

Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff. Incidents were discussed by senior
management at their weekly meeting and the learning was shared with staff. There was a white board in the corridor outside the staffroom that highlighted the trends from incidents reported in the past month and the learning that had been disseminated from these incidents. Learning from incidents was also fed back at the daily handover meeting.

There was a strong culture of reporting, investigating and learning from incidents and we were given examples to changes in processes that had occurred due to learning from serious incidents. To report incidents, staff used an electronic system which had recently been brought in by the trust. Staff were encouraged to report incidents, so that trends could be flagged and learnt from.

Most of the staff we spoke with were aware of the statutory duty of candour principles, however, some staff were less familiar with the principles. The accident and emergency department had a system to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Urgent and Emergency Care.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 533 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- Eight treatment delay meeting the SI criteria
- Five diagnostic incident including delay meeting the SI criteria (including failure to act on test results)
- Three medication incident meeting SI criteria
- Two sub-optimal care of the deteriorating patient meeting the SI criteria
- One for all other categories

The 514 incidents, which related to 12 hour trolley breaches in accident and emergency, that were pending review at the time we obtained the data, have since been reviewed, downgraded and closed in conjunction with the local clinical commissioning groups.

*(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)*

**Safety thermometer**

The department displayed an ‘open and honest’ board in the clinical area that displayed the number of days since the last fall in the department (61), the number of days since the last methicillin-resistant staphylococcus aureus infection (never) and the latest hand hygiene audit results (94%).
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections between August 2016 and August 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

**Major incident awareness and training**

The trust had a major incident policy, which was accessible to staff on the trust intranet. There was a major incident file in place, which had all necessary paperwork in it.

At the time of our last inspection, some staff told us that they were unsure what their roles would be if a major incident occurred. However, at the time of our current inspection, staff had a good understanding of their roles and responsibilities with regard to major incidents. Although the service was not a specific trauma unit, staff told us about a recent major incident where they had received a number of critically injured trauma patients. Staff worked in an outstanding way to deliver care and treatment. The department was rapidly rearranged to facilitate effective treatment for this cohort of patients. Additional staff came in from home without being asked and worked throughout the night to stabilise patients. Staff told us that the major incident process was followed and a trust wide and a departmental debrief was undertaken following the incident. Staff told us they had received help and support from the trust in the aftermath of the incident and support was ongoing for those staff that needed it.

The unit also had a decontamination unit outside of the main entrance for chemical, biological or radiological materials. The decontamination unit was well maintained and staff told us there were regular training and practice days and could explain how they would treat casualties. There was a member of staff allocated the responsibility for chemical, biological, radiological, nuclear, and explosives on each shift and we saw this on the staffing board. There were dedicated chemical, biological, radiological, nuclear, and explosives quality champions (link nurses) for the unit.

**Is the service effective?**

**Evidence-based care and treatment**

There were a range of pathways that complied with the National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These aimed to promote early treatment and improve patient outcomes. We saw evidence of the sepsis pathway in use at the time of our inspection.

We saw evidence that NICE guidelines were discussed at meetings, so changes to guidance could be applied to systems and processes within the accident and emergency department.

The department also took part in national audits, such as those identified by the Royal College of Emergency Medicine.

**Nutrition and hydration**
Hot food was available twice a day at lunch and tea time. Hot food was initially offered to patients who had a long wait and then to other patients. Relatives of patients were also offered food. The housekeeper sought dietary requirements from patients and relatives. Cold food was available 24 hours a day, which consisted of sandwiches and yoghurts. Breakfast options were also available.

We observed staff offering tea and biscuits to a patient and their relatives and asking their preferences on how they liked their hot drinks preparing.

There were vending machines in the adult and paediatric waiting areas. These offered hot and cold drinks and a selection of snacks, such as biscuits, crisps and confectionery. At the time of our inspection, the vending machines were stocked and in use. The hospital also had a large canteen, however, it was not in close proximity to the accident and emergency department.

**Pain relief**

Staff used a pain score tool to assess if a patient had pain. Three different pain scoring tools were used in paediatric accident and emergency, so there were appropriate tools available for a diverse range of children. One example was a ladder system, with different faces on a scale of 1 – 10. The second example was a horizontal score with faces on a scale of 1 – 5. The third example was in use in the sensory room; there were ‘emoji’ cushions that could be used by children who were non-verbal or had learning disabilities, to not only score pain, but also to identify how they felt emotionally at that moment.

We saw evidence that pain scores had been recorded in the records we reviewed.

**Accident and Emergency Survey 2014**

In the CQC accident and emergency survey, the trust scored 6.0 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Were you able to get suitable food or drinks when you were in the accident and emergency department?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

**Accident and Emergency Survey 2014**

In the CQC accident and emergency survey, the trust scored 5.9 for the question “Were you able to get suitable food or drinks when you were in the department?” This was about the same as other trusts.

(Source: CQC Accident and Emergency Survey 2014)

**Patient outcomes**

We saw that the trust had participated in national audits, such as those identified by the Royal College of Emergency Medicine. The results were used to benchmark and compare with other
trusts nationally. There was a clinical audit lead in place for the department and they would lead on audit completion and compliance.

There were nursing audits undertaken by the accident and emergency department that fed in to monitoring patient outcomes, such as a pain audit and an early warning score audit. The department also undertook a vulnerable patients audit.

The trust had made some changes in the accident and emergency department as a result of the Royal College of Emergency Medicine’s audit results. For example, there was now a sepsis ‘deck phone’, which was alerted when a patient with sepsis was enroute or had been identified at triage. The advanced nurse practitioner carried this Monday to Friday and a middle grade doctor out of hours and weekends.

The trust had introduced the rapid assessment bays to aid rapid assessment and undertake tests prior to the patient being seen by a doctor, to aid prompt diagnosis and treatment.

The paediatric accident and emergency were embarking on a project to design their own paediatric warning scores. The department used the paediatric observation priority score but had received funding to design and implement their own early warning score system for paediatric patients.

The accident and emergency department had adopted the venous thromboembolism (VTE1) proforma from the surgery department, for use with patients in lower limb casts, to assess their need for thromboprophylaxis medication.

Royal College of Emergency Medicine Audit: Severe sepsis and septic shock
North Manchester General Hospital:

In the 2016/17 audit for severe sepsis and septic shock, North Manchester General Hospital failed to meet any of the standards. The hospital was in the lower UK quartile (the lowest 25% in the UK) for six measures.

The measures for which North Manchester General Hospital performed in the lower quartile were:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival (0.0%)
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is documented reason not to): Within one hour of arrival (4.1%)
- Standard 4: Serum lactate measured: Within one hour of arrival (4.1%)
- Standard 5: Blood cultures obtained: Within one hour of arrival (4.1%)
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: within one hour of arrival (6.0%)
- Standard 7: Antibiotics administered: Within one hour of arrival (6.0%)

(Source (CQC Insight) Royal College of Emergency Medicine)

North Manchester General Hospital

In the 2015/16 audit for vital signs in children, North Manchester General Hospital was in the
upper quartile (the top 25% in the UK) compared to other trusts for none of the six measures and was in the lower quartile (the lowest 25% in the UK) for three of the six measures.

The measures that performed in the lower quartile were:

- Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score (21.0%) and capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest (6.0%)
- Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set (0.0%)

(Source: Royal College of Emergency Medicine)

Royal College of Emergency Medicine Audit: Venous thromboembolism risk in lower limb immobilisation in plaster cast 2015/16

North Manchester General Hospital

In the 2015/16 audit for lower limb immobilisation in plaster cast, North Manchester General Hospital performed:

- For the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, the hospital had a sample size of 0 cases therefore the measure was NA.
- In the lower quartile for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for venous thromboembolism has been given to all patients with temporary lower limb immobilisation’, with a score of 0.0% in 51 cases.

(Source: Royal College of Emergency Medicine)

Royal College of Emergency Medicine Audit: Procedural sedation in adults (2015/16)

North Manchester General Hospital:

In the 2015/16 procedural sedation in adults audit, North Manchester General Hospital was in the upper quartile (the top 25% in the UK) for none of the measures, the lower quartile (the lowest 25% in the UK) for four measures and the middle quartiles for the remaining three measures.

The measures that performed in the lower quartile were:

- There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded (15.4%)
- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG (0.0%)
- Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area (4.6%)
- Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  
  a. Return to baseline level of consciousness
  b. Vital signs within normal limits for the patient
  c. Absence of respiratory compromise
  d. Absence of significant pain and discomfort
  e. Written advice on discharge for all patients (0.0%)
Unplanned re-attendance rate within 7 days

Between August 2016 and July 2017, the trust’s unplanned re-attendance rate to accident and emergency within seven days was worse than the national standard of 5% and worse than the England average. In the latest period, July 2017, the trust’s performance was 10.0% compared to the England average of 7.7%.

Unplanned re-attendance rate within 7 days - The Pennine Acute Hospitals NHS Trust

At the time of our inspection, we reviewed the unplanned re-attendance rate within seven days for North Manchester General Hospital between November 2016 and October 2017. The data showed that the attendance rate was consistently higher than the trust’s target of 5%. The leadership team were working with the department to decrease the reattendance rate and plot trajectories for improved performance.

Unplanned re-attendance rate within 7 days – North Manchester General Hospital

Competent staff

The accident and emergency department employed a clinical nurse practice educator for 30 hours per week. The clinical nurse practice educator was supernumerary to the planned staffing on the
unit, so was able to allocate the entire 30 hours a week to the training, development, coaching and mentoring of staff in the department. The clinical nurse practice educator provided an outstanding approach to training, development and retention of staff on the unit.

New staff received a planned two week trust induction and a four week supernumerary training programme that was delivered in-house. Staff would not be included in the numbers until they had completed the training programme, however, they were able to request an extension to the supernumerary period if they felt they still had some development needs. The clinical nurse practice educator and the staff member’s mentor would then work with them during the extension period to ensure they felt confident and comfortable working in the accident and emergency department.

The training programme was comprehensive and covered areas including: bereavement, life support (basic, intermediate and advanced), sudden death, organ donation, the Mental Capacity Act and Deprivation of Liberty Safeguards, resuscitation, fluids, early warning scores (adult, paediatric and maternity) and undertaking difficult conversations.

The clinical nurse practice educator also brought in external speakers, including one that was scheduled to come in to do some training on domestic abuse with staff.

The clinical nurse practice educator was also a vocational qualification assessor, so unqualified staff were able to develop and undertake training to enhance their skills.

Training and development in the accident and emergency department was encouraged for all staff at all levels.

The accident and emergency department had development plans tailored for the staff members’ banding and experience. Development plans were phased and included comprehensive objectives and development opportunities. Junior Band 5 staff were able to undertake advanced life support or advanced paediatric life support training as part of their development plan if they were ready. Experienced Band 5 nurses were able to undertake mentorship programmes and become clinical assessors. Band 6 nurses undertook the trust’s leadership and development courses. Band 7 staff had their Personal Development Review completed by the clinical matron and their development plans were adapted to the pathway they were taking, for example management or clinical pathways. There were opportunities for Band 7 staff to develop and train and we were told that there was a mix of both clinical and managerial focused Band 7 staff in the department.

We saw evidence that competencies were in place for staff using all medical devices. Details were held in a file and clearly labelled and all staff had completed medical device training.

The trust has a work experience department and we were told the accident and emergency department had hosted work experience students. The programme was very popular and oversubscribed. Work experience was planned and a contract signed by the students applying. The department also hosted three cadet nurses on a Thursday and Friday each week. Cadets had their own induction. We were told that in the most recent intake of nursing staff, one of their previous cadets had returned as a full time member of staff.

Staff also undertook specific trauma training, despite not being a trauma centre or trauma unit, as there were patients who self-presented with serious trauma injuries, so staff were competent and able to deal with trauma injuries.

There were link nurses for various areas, the accident and emergency department called them quality champions and there were both adult and paediatric nurses for each role covering: alcohol, drugs and homelessness, blood transfusions, basic life support, burns, for chemical, biological, radiological, nuclear, and explosives, continence, dementia, deteriorating patients, diabetes, end of life, falls, infection preventon, learning disability, medicines management, mental health, organ donation, pain, plaster skills, point of care testing, respiratory, resuscitation, safeguarding, sudden death, transfer, trauma, tissue viability and wounds.

**Appraisal rates**
We viewed an up to date report at the time of our inspection which showed 90% of nursing staff in the A&E department had an appraisal. The trust target for appraisals was 90%. This figure was significantly better than the data submitted in the Routine Provider Information Request (RPIR), which is set out below.

NB – data from the following teams have been used for the below as the trust didn’t include a specific Urgent and Emergency Care core service for the appraisal data supplied in the RPIR:

352 BD115 - UCC Clerical (Rochdale), 352 BD311 - Urgent Care Centre (Rochdale), 352 BE404 - Urgent Care Teams, 352 CB100 - Urgent Care Mgmt (Bury), 352 CB102 - Urgent Care Mgmt (Oldham), 352 CB105 - A & E Clerical Support (Bury), 352 CB110 - A&E Reception (North), 352 CB113 - A & E Clerical (Oldham), 352 CB305 - Accident & Emergency (Bury), 352 CB307 - Accident & Emergency (North), 352 CB309 - Accident & Emergency (Oldham), 352 CB322 - A&E - ENPs (North), 352 CB324 - A&E - ENPs (Oldham)

Between June 2016 and May 2017, 69% of staff working within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%.

The 69% appraisal rate applies to nursing and midwifery registered additional clinical services staff, allied health professionals, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At North Manchester General Hospital 65% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. In the paediatric accident and emergency department there were close links with the paediatric department and regular communication around admissions.

We also observed excellent multidisciplinary working within the department. There was a weekly senior manager meeting on a Thursday morning, which was attended by both adult and paediatric representatives in the accident and emergency department. The meeting consisted of multidisciplinary nursing, medical and administrative staff.

Seven-day services

The accident and emergency department was operational 24 hours a day, seven days a week. The x-ray department facilities were next to the department and could be accessed easily from the unit, 24 hours a day, seven days a week.

There was consultant cover in the accident and emergency department between 8am and 10pm, Monday to Friday and 9am and 5pm on Saturday and Sunday. Outside of these hours, consultants were available on call. There was a middle grade doctor available in the department 24 hours a day.

Health promotion

The accident and emergency department had banners, posters and leaflets on display. In the paediatric waiting area, there was a large health promotion display on the dangers of smoking and another health promotion display on the dangers of ‘fidget spinners’, that had been causing some injuries.
In the adult waiting area there were large banners on sepsis recognition, posters on mental health contacts and leaflets for various services and partnership organisations that patients could self refer to.

Patients were given information about their treatment and condition and there were a large number of leaflets to support this.

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

We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the accident and emergency department.

We observed staff providing care to patients and obtaining consent to provide treatment.

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### Is the service caring?

**Compassionate care**

We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed. We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach. We observed staff responding compassionately to patients’ pain, discomfort and emotional distress in a timely and appropriate way. Confidentiality was respected in staff discussions with people and those close to them. One patient told us staff were “very nice, kind and respectful”.

We observed that the unit had received thank you cards from patients and relatives, thanking staff for the support and treatment they had received. The unit also had a ‘glimpse of brilliance’ board that celebrated the positive feedback staff had received for the care they had provided.

### Friends and Family test performance

Between July 2016 and June 2017 the trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was consistently worse than the England average. In the latest period, June 2017 the trust’s performance was 83.7% compared to the England average of 87.6%.

**Accident and Emergency Friends and Family Test Performance - The Pennine Acute Hospitals NHS Trust**
**Emotional support**

There was a room for relatives to use if needed, however, the room was very small and located on a busy corridor. The room provided access to hot drinks and spiritual and religious materials were available. There was support available for the bereaved from the chaplaincy service.

We observed staff supporting patients emotionally and providing assurance to anxious and distressed patients. Staff also supported each other emotionally during difficult shifts and distressing events.

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

Patients told us staff explained their care and treatment to them in a way they could understand. We observed staff communicating in a way that people could understand and was appropriate and respectful. Patients and relatives told us they were kept informed of what was happening and understood what tests or treatment they were waiting for.

One patient we spoke with was waiting for a hospital bed and told us that the nurse had offered to get them a more supportive mattress, so they were more comfortable whilst waiting to be admitted to a ward.

The paediatric accident and emergency department had co-produced the sensory room with input from patients and families, so that the facilities met the needs of those using the room.

**Accident and Emergency Survey 2014**

The results of the CQC accident and emergency survey 2014 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>2014 RAG</th>
<th>Trust 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Were you told how long you would have to wait to be examined?</td>
<td>About the same as other trusts</td>
<td>4.44</td>
</tr>
<tr>
<td>Q10. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>About the same as other trusts</td>
<td>8.15</td>
</tr>
<tr>
<td>Q11. While you were in the accident and emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>7.97</td>
</tr>
<tr>
<td>Q12. Did the doctors and nurses listen to what you had to say?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q15. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>About the same as other trusts</td>
<td>8.70</td>
</tr>
<tr>
<td>Q16. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>About the same as other trusts</td>
<td>7.42</td>
</tr>
<tr>
<td>Q17. While you were in the accident and emergency department, how much information about your condition or treatment was given to you?</td>
<td>About the same as other trusts</td>
<td>8.58</td>
</tr>
<tr>
<td>Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>About the same as other trusts</td>
<td>7.84</td>
</tr>
<tr>
<td>Q20. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Q21. Were you involved as much as you wanted to be in</td>
<td>About the same as other trusts</td>
<td>7.76</td>
</tr>
<tr>
<td>Question</td>
<td>2014 RAG</td>
<td>Trust 2014</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>decisions about your care and treatment?</td>
<td>as other trusts</td>
<td></td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity while you were in the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>8.54</td>
</tr>
<tr>
<td>Q13. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>About the same as other trusts</td>
<td>7.04</td>
</tr>
<tr>
<td>Q22. If you were feeling distressed while you were in the accident and emergency department, did a member of staff help to reassure you?</td>
<td>About the same as other trusts</td>
<td>6.08</td>
</tr>
<tr>
<td>Q24. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.26</td>
</tr>
<tr>
<td>Q25. Before you left the accident and emergency department, did you get the results of your tests?</td>
<td>About the same as other trusts</td>
<td>8.24</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.49</td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>About the same as other trusts</td>
<td>5.22</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>About the same as other trusts</td>
<td>4.66</td>
</tr>
<tr>
<td>Q39. Did hospital staff take your family or home situation into account when you were leaving the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>4.67</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>About the same as other trusts</td>
<td>5.30</td>
</tr>
<tr>
<td>Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>6.99</td>
</tr>
<tr>
<td>Q43. Overall... (please circle a number)</td>
<td>About the same as other trusts</td>
<td>7.80</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

### Is the service responsive?

#### Service delivery to meet the needs of local people

The A&E department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day via the rapid, assessment, interface and discharge team (RAID team).

There was a separate room to assess patients with mental health needs, however, this was not an official section 136 suite. A section 136 suite is a place of safety for patients detained under Section 136 of the Mental Health Act. The room was free of ligature points, had two doors and three panic alarms fitted. Within the room there was one chair only.
There was a separate room to assess patients that had been brought in from police custody and prisoners from the local prison. The room had been risk assessed by the prison service and was regularly used.

GP streaming was used in the accident and emergency department for patients that self-presented and were streamed to the GP on triage, if they were deemed suitable. Patients who were triaged and deemed unsuitable for GP streaming were seen in either the major’s or minor’s area, depending on their condition. Thus, all patients could be seen more quickly by the most appropriate clinician.

There was a separate paediatric accident and emergency and they had close links to the paediatric department within the hospital.

**Meeting people’s individual needs**

There were dedicated disabled toilets available in both the adult and paediatric waiting areas.

The paediatric accident and emergency had a bespoke sensory room for use by patients with specific conditions that would mean their time in accident and emergency would be more comfortable and less frightening; these included patients that presented with mental health conditions, patients with autistic spectrum conditions, learning disabilities and other conditions that could be helped by utilising the sensory room.

Children that presented in adult accident and emergency between the ages of 16 – 17 were assessed using the paediatric proforma, so that their clinical, social and emotional needs could be assessed. If these patients were admitted to an adult ward, staff from accident and emergency would liaise with the bed manager to ensure they were placed in a side room.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were never used for interpreting and if there was a member of staff in the accident and emergency department that spoke the same language they could be used, if appropriate, to put the patient at ease. It is best practice not to use family members for a number of reasons, including reliability of translation and patient confidentiality and staff understood this.

There were no leaflets displayed in languages other than English, but staff told us they had access to leaflets in other languages if they were required.

The accident and emergency department would make reasonable adjustments for patients with learning disabilities. For example they allowed one patient to come in via a different door when the carers had phoned ahead and use the same cubicle at each attendance to reduce the stress and anxiety for the patient. Where possible, they tried to use staff that the patient had already seen previously.

The accident and emergency department had dementia friendly clocks and signage.

The trust had access to the RAID team by telephone 24 hours a day. Staff told us that this team was provided by a partner provider and they were not based on site, so it could cause delays.

The accident and emergency department did not have a viewing room for recently deceased patients. There was a room that could be used if not in use already, however, it was on the main corridor and was opposite the room used for patients presenting with mental health conditions. There were plans to locate a viewing room in the department, but work had not yet started.

The accident and emergency department had local quality champions (link nurses) that could be used as a resource when dealing with patients with individual needs, for example there were quality champions for: alcohol, drugs and homelessness, dementia, diabetes, end of life, learning disability, and mental health. There were nurses from both the adult and paediatric accident and emergency named, so each area had their own quality champion.
Accident and Emergency Survey

The trust scored “about the same” as other trusts for the three survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.22</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Overall, how long did your visit to the accident and emergency department last?</td>
<td>7.79</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you given enough privacy when being examined or treated?</td>
<td>9.00</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

Access and flow

Royal College of Emergency Medicine guidance indicates that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. People could access the service when they needed it. Median waiting times for triage within 15 minutes were in line with good practice 12 out of 13 months, at between 10 and 15 minutes between October 2016 and September 2017. The highest median triage time was 16 minutes during December 2016.

At the time of our inspection, we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using streaming to direct patients to the most appropriate care setting and rapid assessment to make sure that any tests, such as bloods or electrocardiograms were undertaken whilst the patient waited to see a doctor. Staff reported that this had a positive impact on waiting times and were hopeful that the number of patients waiting more than four hours would reduce.

The paediatric accident and emergency department worked with the flow coordinator employed by the paediatric department to identify bed vacancies and improve flow in the department. Staff we spoke with told us that this role had been invaluable and had significantly improved the flow between the paediatric accident and emergency and the paediatric wards.

The senior consultant and clinical matron undertook two hourly quality rounds within the accident and emergency department. The quality rounds not only assessed the quality of the care delivered in the department, but also helped alleviate bed pressures and flow issues. They assessed every patient and their records and where possible when they could identify patients who would benefit from an alternative treatment, they would ensure that the plan for this patient was reviewed and treatment changed as necessary. For example we were told about a patient who was newly diagnosed with cancer, but was otherwise fit and well; instead of admitting the patient and waiting for a bed, they were able to discharge the patient with a rapid referral to access treatment from a specialist in the same week, ensuring the best outcome for the patient and helping to alleviate pressure on beds.

From our observations and discussions with patients and staff, patients were triaged and assessed quickly. There were boards in the waiting areas that clearly stated waiting times and the nurse in charge of triage for that area. According to the waiting boards, patients were being triaged within 15 minutes at the time of our inspection.

The accident and emergency department used emergency nurse practitioners (ENPs) in the minor’s area, where there was a secondary triage room. Staff told us that this had helped identify and treat more minor injuries, resulting in better flow and greater patient satisfaction.

Bed meetings took place three times a day at 8.30am, 12pm and 4pm. We observed that they were attended by multidisciplinary staff and senior director staff. Waiting times were reviewed and breaches and potential breaches discussed. Escalation was efficient and action was taken to
ensure there were beds made available for patients waiting to be admitted from accident and emergency.

The accident and emergency department did not have a clinical decisions unit or separate ward area that patients awaiting admission could be moved to, so some patients who were waiting a long time for admission were still in accident and emergency overnight or waiting for over 12 hours. The department was working hard to reduce the risks for patients who had long waits, such as by moving patients from trolleys to hospital beds and using pressure relieving equipment for patients who were a high risk of developing pressure sores.

The chart below shows the trust were working hard to reduce the number of patients in the accident and emergency department for more than 18 hours. The figures had significantly reduced in the past three months.

**Patients in the department for over 18 hours**

(Source: URGENT CARE PERFORMANCE DASHBOARD - NMGH View)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

At the time of our inspection were able to view the performance for North Manchester General Hospital from April 2017 to October 2017. The figure improved month on month and although still under the 95% target, the increase is on a positive trajectory.

Four hour target performance – North Manchester General Hospital
The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the accident and emergency. The trust failed to meet and subsequently breached the standard for each month during the period September 2016 to August 2017.

From March 2017 onwards performance against this metric has shown a general trend of improvement, peaking in May 2017 but still showing an upward trend towards the standard for June 2017 to August 2017.

Throughout the period the trust’s performance, although consistently below the England average, has followed a similar trend to it.

Four hour target performance - The Pennine Acute Hospitals NHS Trust

(Source: URGENT CARE PERFORMANCE DASHBOARD - NMGH View)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

Between September 2016 and August 2017 the trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was higher than the England average.

Performance against this metric showed a trend of improvement from October 2016 onwards where the percentage of patients waiting between four and 12 hours has decreased steadily,
moving closer in line with the England average. May 2017 saw the lowest percentage of patients waiting between four and 12 hours throughout the period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Pennine Acute Hospitals NHS Trust**

(Source: NHS England - Accident and Emergency Waiting times).

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from September 2016 and August 2017, 721 patients waited more than 12 hours from the decision to admit until being admitted.

The highest numbers of patients waiting over 12 hours were in October 2016 with 129 patients, January 2017 with 125 patients and February 2017 with 113 patients.

For October 2016 and February 2017 the trust had the highest number of patients waiting over 12 hours out of all NHS acute trusts.

At the time of our inspection we were able to compare the figures from September and October 2016 to the most recent figures from September and October 2017. The trust has shown a positive improvement and significantly reduced the numbers of patients waiting between 4 and 12 hours and the number of patients waiting over 12 hours.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-16</td>
<td>1137</td>
<td>36</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1633</td>
<td>129</td>
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<tr>
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<tr>
<td>Dec-16</td>
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</tr>
<tr>
<td>Feb-17</td>
<td>1122</td>
<td>113</td>
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</table>
Additional data available at the time of our inspection:

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<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
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</thead>
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<tr>
<td>Sep-17</td>
<td>726</td>
<td>6</td>
</tr>
<tr>
<td>Oct-17</td>
<td>691</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: NHS England - Accident and Emergency Waiting times)

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

Between September 2016 and July 2017 the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was higher than the England average. However performance against this metric has shown a trend of improvement with the median percentage decreasing slightly from its peak in December 2016.

From May 2017 onwards performance has become more in line with the England average. In the latest period, July 2017, the median percentage for the trust was 3.5%, compared to the England average of 3.4%

At the time of our inspection, data for August 2017 and September 2017 was available. The total percentage of patients who left before being seen in August was 2.9% against an England average of 3%. In September the total percentage of patients leaving before being seen was 2.8% against an England average of 3.2% which shows an improving picture.

Percentage of patients that left the trust without being seen - The Pennine Acute Hospitals NHS Trust

(Source: NHS DIGITAL - Accident and Emergency quality indicators)

Median total time in accident and emergency per patient (all patients)

Between September 2016 and July 2017 the trust's monthly median total time in accident and
emergency for all patients was consistently higher than the England average. May 2017 was the month where the trust's median total time in accident and emergency of 151 minutes was closest to the England average of 148 minutes.

**Median total time in accident and emergency per patient - The Pennine Acute Hospitals NHS Trust**

![Graph showing median total time in accident and emergency per patient](image)

(Source: NHS DIGITAL - Accident and emergency quality indicators)

**Accident and Emergency Survey**

The trust scored “about the same” as other trusts for the three survey questions relevant to the responsive domain.

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<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>Q5. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.22</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Overall, how long did your visit to the accident and emergency department last?</td>
<td>7.79</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you given enough privacy when being examined or treated?</td>
<td>9.00</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

**Summary of complaints**

Between June 2016 and May 2017 there were 149 complaints about Urgent and Emergency Care services (18.3% of all complaints).

The trust took an average of 63 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 39 complaints still open and yet to be completed.

There were 93 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 62%.

North Manchester General Hospital: There were 67 complaints (45.0%)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Learning from complaints and concerns**
Between June 2017 and September 2017 there were 14 new complaints relating to urgent and emergency care at North Manchester General Hospital.

Staff told us that complaints were recorded on the electronic incident system, as this also helped to flag trends to senior managers and disseminate learning to staff.

There was a whiteboard displayed outside the staffroom that had learning from complaints and incidents displayed and showed staff the action taken and whether there was a trend in complaints. Complaints feedback was also relayed during handovers and team meetings. We were told that staff who had been the subject of a complaint would be spoken to, to pass on feedback and learning points. Staff who had been subject to positive feedback through a complaint would also be given the positive feedback.

Complaints could be made via telephoning or emailing the trust, the Patient Advocacy and Liaison Service (PALS) and the matron told us that she would call back those patients who wished to speak on the phone.

**Is the service well-led?**

**Leadership**

The trust restructured since the last inspection and moved to a care organisation model for each of their locations. The North Manchester care organisation had three divisions, of which the accident and emergency department was part of the division of integrated medicine. A triumvirate of a divisional clinical director, a divisional managing director and a divisional director of nursing led the division of integrated medicine. The department sat under the emergency and urgent care directorate, which had a directorate manager; a clinical director, an assistant director of nursing, a vacant clinical lead post for accident and emergency and a vacant clinical lead post for AMU. This structure provided direct nursing and medical leadership.

The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability. Staff said leaders were visible and approachable. A member of the senior director team had undertaken some shifts in the accident and emergency department and staff told us that senior managers were aware of the local challenges the department faced.

The accident and emergency department had clear management structures at divisional, directorate and departmental levels. The managers knew about the quality issues, priorities and challenges and worked collaboratively site-wide to try and deliver solutions and pilot new ways of working. We observed that managers were proactive and their positivity and motivation was inspirational.

The leadership team demonstrated a clear and innovative approach to assessing and managing patient flow and safety within the accident and emergency department. They had introduced a clearer escalation process, which aimed to provide a consistent approach in times of pressure. Staff told us it was now escalation for action, whereas in the past it seemed to be more escalation for information. There was a clear commitment and focus by all senior leaders to predict and respond to patient demand and flow issues within the accident and emergency department and this was clearly supported by all other departments in the hospital. Staff told us that pressures in accident and emergency were seen as a site wide responsibility. We observed several bed meetings and there were director team members and senior leaders in attendance, driving flow issues and looking for solutions.

**Vision and Strategy**
The trust had a clear vision and strategy that was quality driven and which looked to transform patient access to urgent and emergency care. The A&E department was providing a GP streaming service and used emergency nurse practitioners (ENPs) and advanced nurse practitioners (ANPs) as part of a transformational approach to staffing the unit. A band 8b paediatric ANP role was being re-titled ‘nurse consultant’ to reflect the responsibility and seniority of the post.

There were plans to recruit an additional band 8b ANP to work with the assistant director of nursing and provide direct leadership to the four ANP posts currently working in the accident and emergency department.

We were told that the strategic plan for the service set out realistic objectives for the future growth and sustainability of the accident and emergency department in line with national priorities. A positive trajectory for improvement had been plotted to meet national standards, where targets were not currently being met.

**Culture**

We found the culture of the accident and emergency department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders. We asked staff about the morale of the department and they all said that morale was generally good and they worked collaboratively as a team. Staff felt there were still some pressures around staffing, but the service had much improved since the last inspection and staff were proud to work there.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff.

Staff also felt that they could raise ideas that could be potential solutions to the accident and emergency departments issues and they would be taken seriously and their ideas considered by the management team.

Staff we spoke with wanted to provide effective care and treatment to patients and put patients at the centre of the experience. We observed staff working well together and there were positive working relationships within the multidisciplinary teams.

Staff at all levels also told us that although achieving targets was important they recognised that this was not always possible, however, they were working hard to meet the trajectory that had been set in terms of national targets and standards.

**Governance**

The accident and emergency department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the strategy and provided continuing assurance up to board level, with the clear focus on patient safety.

We reviewed the minutes from the ED Directorate Assurance and Risk Committee. The agenda items included: risk register / governance, incidents and complaints, training and development, performance, staffing, finance, clinical audit programme, policies and procedures and NICE guidance.

There was a weekly senior manager meeting on a Thursday morning attended by both adult and paediatric representatives in the accident and emergency department. The meeting consisted of multidisciplinary nursing, medical and administrative staff. Issues and learning from this meeting would be cascaded through the department.

**Management of risk, issues and performance**

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. The matron displayed the
risk register for staff to familiarise themselves with and understand the key risks and issues for the accident and emergency department.

Managers told us that the escalation process was effective; issues were now escalated for action rather than for information and action was taken promptly to rectify the issue.

At the time of the last inspection, quality measurement in the service was limited. We found at the current inspection that the accident and emergency department had a clinical lead who was responsible for clinical audits, to assess the quality of care and treatment provided.

**Information Management**

Staff were able to access patient information using an electronic system and paper records. The accident and emergency department used an electronic system to track patients from presentation to discharge. The system colour coded patients after triage, depending on whether they were paediatric (pink), minor injury (green), GP streamed (pale blue) or emergency/major injury (dark blue). This provided a visual overview of who was in the department at any one time and provided a breakdown of patients and waiting times. The system also provided reports to track any patients approaching a breach of four or 12 hours, which fed in to the daily bed meetings. Information collated was used to monitor, manage and report on quality via the quality dashboard that was submitted on a monthly basis.

The accident and emergency department used another system for test results from the pathology lab. Some members of staff told us that the system was very slow and could cause issues, however, they also told us that they could call the lab and any abnormal results would trigger the pathology lab to call the department to alert them, rather than relying solely on the electronic system.

At the time of our inspection, we observed several computer stations around the unit were left unlocked and unattended, this could mean that unauthorised persons could gain access to patient records. Staff told us that they routinely locked the stations to protect patient data, however, we did not see this at all times.

**Engagement**

Staff told us that they had started using Twitter as a public engagement tool. Areas they had ‘tweeted’ about included the intake of a new cohort of nursing staff and the GP streaming service in the accident and emergency department that was currently in operation.

Paediatric staff told us that they had co-produced the sensory room in the paediatric accident and emergency with the input of children and families. There were plans to co-produce further areas, with input from the public, such as a room for children waiting for Child and Adolescent Mental Health Services (CAMHS) intervention and an area for adolescent children, so the department was designed with and for the full spectrum of children it treated.

The accident and emergency department participated in the friends and family test and the NHS and CQC surveys. The most recent friends and family data was displayed on the ‘open and honest’ board and showed 82% patients would recommend the department to their friends and family. The matron also kept staff feedback on a board near the staffroom, this feedback was from staff who had friends or family who had been treated in the department and it was all positive.

The paediatric accident and emergency department had a ‘tops and pants’ feedback box for children to submit their feedback about the department so this could be used to improve and evaluate the service.

**Learning, continuous improvement and innovation**

Staff at all levels were encouraged and supported to explore innovative ways of working. Departmental leaders drove continuous improvement and there was a clear, proactive approach to
seeking out and embedding new and more sustainable models of care. Staff were able to suggest alternative ways of working and these were piloted in the accident and emergency department. There was a suggestions box in the staffroom and staff told us that they had suggested ideas that had been piloted and embedded in to practice.

The leadership had used some innovative approaches to recruiting and retaining new and talented medical staff to the accident and emergency department, including the offer of further education at Master level at a local university. The leadership team understood their financial constraints and had looked for appealing ways to attract high calibre staff, which had resulted in the recruitment of four new consultants.

After the success of the sensory room, the paediatric accident and emergency department had plans to develop areas for CAMHS presentations and asolescent patients in conjunction with children and their families so that the department had more suitable areas for older patients and patients presenting in mental health crisis.

The leadership team were working hard to set a positive trajectory to ensure that the accident and emergency department was meeting government standards, we saw that this reflected in the dashboards we were provided with.
Medical care (including older people’s care)

Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all services).

North Manchester General Hospital provides medical care across nine wards and covers a range of specialities which include cardiology, coronary care, regional infectious diseases service, respiratory, patient investigation unit and complex discharge planning, diabetes/endocrinology, general medicine and care of the older person.

Respiratory inpatient, outpatient and day-case services are also provided. This includes Integrated Lung Cancer clinics that form part of the integrated network lung cancer pathway and provide diagnostic services.

The Programmed Investigation Unit provides medical day case facilities and undertakes planned medical investigations and treatments. The unit is open five days a week, Monday to Friday.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 84,153 medical admissions between June 2016 and May 2017. Emergency admissions accounted for 43,207 (51.4%), 1,779 (2.1%) were elective, and the remaining 39,167 (46.5%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 45,655
- Gastroenterology: 12,034
- Clinical Haematology: 11,993

(Source: CQC Insight)

Is the service safe?

Mandatory training

The service mandatory training for key skills had improved and the majority of training rates met the trust targets.

The hospital managers we spoke with recognised that some areas of mandatory training completion needed to be improved. They informed us they monitored mandatory training rates and these had increased over the last 12 months. However, they did acknowledge that some areas were below 90% such as safeguarding on at least three wards.

Staff spoken with told us that they completed mandatory training such as infection prevention, and moving and handling. Records reflected that all new starters were included in mandatory training figures and this could reduce the percentage of completion rates whilst their training was arranged and completed.

Staff spoke with stated that overall they were given the opportunity to attend mandatory training and were confident that on an individual basis they were able to maintain appropriate training levels.

Mandatory training completion rates

The trust set a target of 90% completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in the Medicine division are shown below:
Medical and dental staff in the medicine division failed to meet the 90% target for mandatory training compliance for all of the 16 modules.

Paediatric basic life support and basic life support training had the lowest compliance levels with only 36% and 52% of eligible medical and dental staff having been trained.

Nursing and midwifery staff in the medicine division met the 90% target for mandatory training compliance in two modules (waste management and infection prevention non-patients).

Immediate life support and paediatric immediate life support training had the lowest compliance levels with only 44% and 48% of eligible nursing and midwifery staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
We looked at the arrangements to make sure that staff received training specific to their job role. This was not consistent, with some staff not receiving training applicable to their job role. For example; staff working on the cardiac care unit had not received training or been assessed as competent in the use of continuous cardiac monitoring (telemetry) in order to maintain patient safety.

Staff told us and management confirmed that informal training took place peer to peer for cardiac monitoring and that there was no formal training programme that ensured staff were given the correct information to safely carry out their job role.

In North Manchester General Hospital, there were no children’s wards inspected as part of the medicine division and paediatric care compliance levels were not relevant to the findings of the report.

**Safeguarding**

Staff understood and were able to explain how to raise a safeguarding concern if they thought a patient maybe at risk of harm.

Nursing, medical and administration staff we spoke with were able to explain the process for safeguarding a patient and provided us with specific examples as to when they would do this. We saw that staff were able to access the trust safeguarding guidelines, which were readily available. This provided information on how to make referrals when staff had concerns about a child or adults’ safety.

Junior staff told us any safeguarding concerns were escalated to a senior nurse and doctor.

Staff were aware of safeguarding processes for child exploitation and female genital mutilation (FGM). This was covered within the safeguarding training.

Staff told us that they had level one training yearly and senior staff had level three training every three years. Records we reviewed confirmed this.

Discussion with management and records showed that level three training completion was not consistently met at 90%. However some areas had exceeded the 90% target and overall the rates of level three training had continued to improve.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing staff working in the Medicine division is shown below:
The 90% target was not met for any of the safeguarding modules by medical and dental staff in the medicine division at the trust. Level 2 adults and children’s training was completed by 251 and 250 of the 294 eligible staff members, however this didn’t equate to 90% compliance. Compliance for level 3 adults was the lowest, with only 56 of the 110 eligible staff members completing the training.

Nursing and midwifery staff in the medicine division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

The service did not consistently control infection risk well.

Staff and management spoken with told us that the Acute Medical Unit (AMU) did not have separate sluicing facilities in order for them to dispose of contaminated laundry or disposable
items. Staff told us that they utilised a sink and toilet facility to undertake these activities. On occasions contaminated items needed to be transported through clean areas in order that they could be correctly disposed of. The infection risk from this unit was identified at the last. Following the inspection the service informed us that two separate sluicing facilities were available on the unit.

Although a risk assessment was in place to try and mitigate the risks, staff and management informed us that it was recognised that this was not an ideal approach and put into place a variety of actions to reduce the risks. However a long term solution such as appropriate sluicing facilities had not been finalised.

There were few side rooms available on medical wards which meant that it was not always possible to isolate patients as required. Although ward J6 was a ward of side rooms the other wards we viewed were open style wards which limited the ability to isolate patients with infections to prevent the spread of infection.

We reviewed a variety of ward areas including the sluice, administration stations and meeting rooms these were visibly clean and tidy.

Throughout North Manchester General Hospital we saw that there needle sharp bins for the disposal of contaminated needles. These were easily accessed by staff.

We observed that staff adhered to the infection control policy and used personal protective equipment (PPE), such as plastic aprons and gloves, when delivering personal care to patients. We observed medical and nursing staff following the trust policy for hand washing and ‘bare below the elbows’ guidance in clinical areas.

There were adequate hand washing facilities throughout the division and hand gel dispensers were available as needed.

We spoke with domestic staff whose main role was to assist with the hygiene and cleanliness. They spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed the trust infection control policy.

We looked at cleaning cupboards in a variety of wards and saw that equipment such as coloured mops and buckets were available and stored correctly. Cleaning chemicals had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.

Medical wards displayed the outcomes of their hand washing audits. All the audits that we saw on the medical wards were at 100% compliance.

Curtains on the wards appeared visibly clean but were made of material that was not disposable. We were informed that a system was in place to ensure that curtains were cleaned or changed at least once every six months.

We saw that handwashing; catheter and cannula audits were carried out by infection prevention and control link nurses to ensure compliance with National Institute of Health and Care Excellence (NICE) guidance to reduce the risk of infection.

Environment and equipment

In the majority of areas the environment was suitable for care and treatment and adaptations were made or planned where necessary to meet the needs of patients. However this was not consistent throughout the hospital.

The Ambulatory Care unit had not been adapted to suitably meet patients’ needs. This included lack of access to computers for staff, lack of storage for sharps disposable, lack of room within the unit for patients to be seen in a dignified manner and their confidentiality maintained. Management staff confirmed that the environment remained unsuitable but there were confirmed dates in plans as to when these issues would be resolved.
The managers and staff had identified that there were risks associated with the environment particularly the open type wards in relation to same sex management, patient flow and infection control. There were interim plans in development to relocate some medical services but no agreed plans to address the issue of configured wards.

The monitoring of emergency resuscitation equipment had improved since our last inspection. All of the emergency trolleys we looked at were stocked correctly and located in an area which was easy to access in the event of an emergency. All trolleys sampled contained consumables which were within the expiry date and the relevant equipment which was checked on a daily basis ensuring that if the equipment was needed it was suitable to meet the needs of patients.

Patients who had been identified as at risk of developing pressure ulcers were provided with appropriate mattresses and cushions as assessed.

Assessing and responding to patient risk

The service did not consistently manage risks well.

Intentional rounding was not always completed on time or in an effective way. Intentional rounding is a formal system used to periodically check on patients in order to improve patients’ experience and ensure that care is safe and reliable. Records did not always record the times and actions taken of intentional rounding. Records showed and were confirmed by the trust that intentional rounding records were incomplete. With missed periods when this should have occurred and recorded. There was a lack of explanation as to why the intentional round was missed. For example, of the records we reviewed throughout the hospital for intentional rounding none had been fully completed and all contained gaps that indicated rounds had not taken place in order to meet patients’ needs.

Risks to patients were not consistently recognised and addressed although we saw evidence of good practice in areas of the hospital. Risks were identified with staff highlighting concerns in relation to patients both in records and at meetings. However, when we looked at the computer system meant to contain copies of the completed risk assessments we saw that these were not consistently completed with appropriate actions detailed.

Staff used an “information sharing” online form to alert relevant parties if there were concerns. This included social services and safeguarding teams. There was a comprehensive list of reasons why this form may be used. Staff were able to report concerns that were not on the list if they felt this was necessary.

We observed board rounds and handovers. Risks were discussed at these meetings and recorded in handover records. However, these risks were not consistently discussed nor were the required actions highlighted clearly.

Records showed that there had been an improvement in monitoring and recognising changes in patients’ conditions when they deteriorated and appropriate action was taken to reduce the risks identified at this time.

Nursing staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in medicine for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
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<p>| Medicine |   |
|----------|---|---|</p>
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<tr>
<th><strong>Month</strong></th>
<th><strong>WTE in post</strong></th>
<th><strong>WTE planned</strong></th>
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</thead>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 16</td>
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<td>January 17</td>
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<td>February 17</td>
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<td>March 17</td>
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<tr>
<td>April 17</td>
<td>437.23</td>
<td>533.34</td>
</tr>
<tr>
<td>May 17</td>
<td>434.07</td>
<td>544.75</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 16.9% for nursing and midwifery staff in medicine;

- North Manchester General Hospital: 20.1%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.3% for nursing and midwifery staff in medicine;

- North Manchester General Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 4.3% for nursing and midwifery staff in medicine, which is in line with the trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 4.3%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Where there were staffing shortages, managers and shift coordinators would provide care for patients which prevented them from carrying out their role specific tasks and having good oversight of what was happening across the ward.

Although the medical wards were not consistently fully staffed, managers had put measures in place to reduce risks to patients. As an example on one ward we saw that a pharmacy technician had been trained to administer oral medicines for morning and lunch time medicine rounds. This assisted in freeing nurses to provide care and support. On another ward, the ward clerk had been given additional hours to answer phone calls and to deal with enquiries from patients’ relatives.

The skills mix of staff was an issue across the hospital. We found instances where newly qualified nursing staff were allocated as shift coordinator and were still required to care for patients. Some of the staff we spoke with told us that this was a responsibility they didn’t feel they had enough experience to undertake and that it caused them additional stress and concern.

Managers informed us of a staffing review which had taken place to address issues across the hospital and re-evaluate nursing establishment levels. Patients’ needs had not been taken into account when assessing nursing and health care workers staffing levels in order to ensure there were enough staff to meet those needs. As such patients who required a higher level of support or
observations were not consistently taken into account in order to determine the staffing levels needed. Instead, the hospital used the “safer staffing tool” to determine the amount of staff needed. As a result staffing was based on numbers of patients and not on their specific needs.

Staff reported that there had been improvements since the last inspection as the number of staff relocated to other wards to cover staffing gaps had decreased. However, they did report that this did still happen and on occasions they felt they did not always have the correct skills for the area that they were relocated to. Management staff confirmed that staff skills and experience was taken into account prior to relocating the member of staff.

Senior management confirmed that there remained a high usage of bank and agency staff. This remained a difficulty throughout the area. However, there was an ongoing recruitment programme to address this issue. Senior management had attended overseas recruitment days in order to assist in obtaining and retaining suitable nursing staff.

In the RPIR the following medical wards were listed as three of the five wards across the trust with the highest bank or agency use.

- CG316 Acute Medical Unit – Royal Oldham Hospital
- CJ312 Ward E1 – North Manchester General Hospital
- CH316 Ward 21 – Fairfield General Hospital

This high use of vacancy and bank staff on these wards was attributed to high vacancy rates, long term sickness and absence.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Consultants told us that although there had been an increase in medical staffing, there were still gaps. However, they thought overall the vacancy rate had improved and that the majority of time there were suitable medical staff available. This was confirmed by senior management who highlighted and described ongoing arrangements in place to recruit and retain staff.

The trust has reported the following planned and actual staffing figures for medical and dental staff working in medicine for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Medicine WTE in post</th>
<th>Medicine WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>120.06</td>
<td>131.52</td>
</tr>
<tr>
<td>January 17</td>
<td>118.06</td>
<td>131.52</td>
</tr>
<tr>
<td>February 17</td>
<td>118.76</td>
<td>131.52</td>
</tr>
<tr>
<td>March 17</td>
<td>119.46</td>
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<tr>
<td>April 17</td>
<td>120.06</td>
<td>131.52</td>
</tr>
<tr>
<td>May 17</td>
<td>120.86</td>
<td>131.52</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates
Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.2% for medical and dental staff in medicine;
  - North Manchester General Hospital: 4.8%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 2.1% for medical staff in medicine;
  - North Manchester General Hospital: 3.1%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 0.3% for medical staff in medicine which is better than the overall trust target of 4.6% for sickness rates.
  - North Manchester General Hospital: 0.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average whilst the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the 252 whole time equivalent staff working in Medicine at The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>25%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/05/2017 - 31/05/2017)

Records

Staff did not consistently keep appropriate records of patients’ care and treatment.

In all the 36 records we viewed there were incomplete records, inaccurately completed records or records missing. This included risk assessments, fluid balance charts, intentional rounding, care
plans for cognitive impairment, transfer records between wards known as an SBAR, Do not attempt cardio pulmonary resuscitation (known as DNACPR) and capacity assessments for patients with cognitive impairment.

Of the 36 records reviewed we saw that there were risks to patients that had not consistently been recorded in 19 records. There were examples where risk assessments had been marked as completed on the electronic recording system but when opened were incomplete.

Some nursing, allied health professionals and medical records were paper based, although medicines were prescribed and their administration recorded electronically. Additionally there were two separate electronic systems in use. If a patient came in via an emergency admission a specific system was used. However within other areas of the hospital this was a completely separate system. This meant that staff had to work with a variety of different systems and they found this on occasions was time consuming. By the time patients were due to be discharged, the records had become chaotic and it was difficult for staff to determine what records were relevant to support the patient prior to their discharge.

The hospital had implemented a system known as the Nursing Assessment and Accreditation System (NAAS), part of this looked at the quality of record keeping. Managers and staff spoken with reported that failings in record keeping had been identified in this process. We saw that where this had been put into place, there had been improvements in the record keeping and the quality of records had continued to improve.

Where records were fully completed these were completed to a suitable standard and often highlighted clear plans of patient care and patient monitoring.

The trollies for storage of patient records, we observed, had digital locks on them in order to maintain the security of the record and the confidentiality of patients.

**Medicines**

The service did not consistently manage medicines safely.

Although generally medicines were found to be stored correctly and securely, we found two wards where medicines were stored in areas where the temperature had exceeded manufacturer’s recommendations. Over the past month, ambient temperatures were recorded as consistently having exceeded 28 degrees and the fridge temperature was recorded as exceeding the maximum eight degrees on a daily basis. This was an ongoing issue of which staff were aware. Staff informed us that storage temperatures had been a problem for at least the past six months with no resolution having been found. The majority of the medicines had manufacturer recommendations stating that the medicines were not to be stored above 24 or 25 degrees. As a result the effectiveness of the medications may have been affected.

Thickening agents used to aid patients with difficulties swallowing were not always stored in a locked cabinet when not in use. We saw that on three wards, thickener had been left on a patient’s table. We identified this to the lead nurse who immediately removed the thickener.

When medicines were prescribed as needed (PRN) there were not always sufficient instructions or monitoring for nursing staff to ensure that the medicine was given appropriately. As an example, one patient was prescribed a sedative for “agitation”; the corresponding care plan that would have outlined the circumstances for this was not available. Although this medicine had been given twice, there was no record as to why it had been given or if the anticipated effect had occurred. As such staff were not monitoring the effectiveness of the medicine to meet the patient’s needs.

We checked that medicines reconciliation had been completed within 24 hours of admission. Of the 15 records checked all had been completed in line with local and national guidance.

We reviewed five patients who were receiving oxygen and found this had been appropriately prescribed on their medicines chart in line with trust policy.
There were guidelines for the self-administration of medicines by patients and there were different levels of self-administration that were appropriately supported by staff and described in the majority of patient records as applicable.

The majority of medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.

**Incidents**

The service managed patient safety incidents well.

Staff told us they were familiar with and encouraged to use the trust’s policy and procedures for reporting incidents.

We saw that incidents were reported through the trust’s electronic reporting system and monitored by management on a daily basis. The time it took to review and action incident reports varied as it was the responsibility of one person to monitor these.

Staff spoken with were able to provide us with examples of when they had reported incidents, and understood what constituted an incident. For example, when a patient had fallen or when medication had been missed.

Staff told us they received feedback following investigations. Learning from incidents was discussed and cascaded through several forums, including departmental meetings, email, notices, team days out and staff handovers.

We saw that one incident raised during our inspection was immediately reviewed. The following day at the staff handover, lessons that had been identified from the review were explained to staff with corrective actions described in order to maintain patient safety.

The hospital had a bulletin as a means to share lessons learned from reported falls incidents to improve safety, reduce risks of falls and improve patient care. We saw an example of this bulletin that detailed a case study and explained to staff the lessons learnt and how to maintain the safety of patients in the future.

The department had a system to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result, this is known as the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Any unexpected deaths or potentially avoidable deaths that occurred in the department were reviewed and discussed at mortality meetings. This meant any patterns and trends could be reviewed and lessons to maintain safety could be identified. Managers told us that any immediate learning following an incident would be discussed directly with the individual member of staff involved in the form of a debrief.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Medicine.

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 41 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 14 slips/trips/falls meeting SI criteria (34% of total incidents)
- 11 all other categories (27% of total incidents)
- 6 sub-optimal care of the deteriorating patient meeting SI criteria
- 4 VTE meeting SI criteria
- 3 treatment delay meeting SI criteria
- 3 HCAI/Infection control incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The hospital was monitoring incidents of pressure ulcers and falls through their performance dashboard each month and these were reported to the trust Executive Quality and Patient Experience Governance Committee.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 41 new pressure ulcers, 29 falls with harm and 24 new catheter urinary tract infections between August 2016 and August 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Pennine Acute Hospitals NHS Trust
Pressure ulcers were recorded for every month during the period aside from June 2017.
Falls were recorded for every month during the period.
CUTIs were recorded for all months during the period except September 2016 and March 2017.
(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff did not always have access to up-to-date, accurate and comprehensive information on patients’ care and treatment.

The service had a bundle in place for patients with Acute Kidney Injury (AKI) however the medical staff we spoke to were not aware of this. We saw no evidence of care plans being completed for those with AKI and specialist input for this group of patients was poorly documented. Medical staff informed us that a nephrologist would visit patients with AKI admitted to a medical ward once a week. We were not assured that the hospital was following clinical guidelines based on best available evidence in order to care for patients with AKI. When asked, clinical leads were uncertain of any audits that monitored the outcomes of patients with AKI and they were not aware of who the lead specialist was for this area.

Care pathways and plans were not regularly reviewed, such as those for patients with cognitive impairment or at risk of sepsis. Sepsis is a potentially life-threatening condition; however it can be easily treated if identified early. When we spoke to staff they were able to confidently discuss signs of sepsis and management of sepsis in line with the Surviving Sepsis Campaign guidelines available throughout the service. Staff confirmed that they followed the services’ sepsis management guidelines, which included implementation of the sepsis six care bundle along with guidelines for ongoing management.

There were local pathways in place to support decision making in line with best practice guidance. We saw that these were readily accessible by staff online. Records reviewed showed that the pathways and care plans were not consistently put into place. We saw three patients’ records where cognitive impairment had been identified but no corresponding pathway/plan had been put into place for staff to deliver appropriate care and treatment.
Patients received an assessment of their risk of a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality statement (QS) 66.

Local audits were carried out in the infectious diseases team. These included tuberculous screening for HIV positive patients, hepatitis and immunisation in HIV. The alcohol liaison team audited the use of vitamin prophylaxis and had developed actions to improve education of staff in this area. Management spoken with were particularly proud of their work with HIV positive patients both in the hospital and the wider community.

The trust and the hospital were addressing falls prevention with guidance from the Royal College of Physicians. However, staff confirmed that the level of unobserved falls remained high.

The Acute Medical Unit had also taken the step to remove commodes from the unit as part of the End PJ Paralysis campaign. End PJ Paralysis is a national campaign which encourages hospital patients, where appropriate, to dress in their own clothes and mobilise as much as possible in attempt to aid recovery. The removal of commodes from the unit encourages patients to mobilise to the toilet if they are able to do so. The falls team at the hospital had raised concerns that this change might result in an increase in falls but these concerns had not been realised.

Nutrition and hydration

Patients’ diet and fluids were not effectively monitored in order to make sure they had sufficient food and drink.

Patients told us they had access to food and drink on request and that there was a good selection of meals available. Meals were available which catered to people’s cultural and religious needs and preferences. However, patients’ diet and fluid intake were not effectively monitored to make sure they had sufficient food and drink. As such if a patient was dehydrated or malnourished, the lack of correct monitoring would fail to inform staff when to take appropriate action.

Managers confirmed that the records were used as part of their ongoing assessment of the quality of the care available but there was no formal basis to check the accuracy of these records on a daily basis.

Two relatives we spoke with raised concerns that their relatives were not supported to eat and drink and that food was often left in front of their relatives only to be removed later uneaten. We looked at how the service identified patients at risk of poor nutrition and dehydration. There was no system consistently in use such as the red tray system. The red tray system is where red tableware such as jugs and trays are provided to patients at risk to prompt additional support. We spoke with staff on two wards who identified that some of their patients were at risk of poor nutrition but that the red tray system was not in usage.

Pain relief

The management of pain for patients was not consistently monitored. Pain scores for patients were inconsistently recorded, monitored and actioned.

This was particularly noted for patients with a cognitive impairment where the assessment of pain is more complex. There were no arrangements in place that assisted staff to identify patients with cognitive impairment or complex needs in order to identify their levels of pain and address this accordingly. Staff informed us that there was a tool that involved family members but this was not always correctly utilised.

Records we reviewed showed that where pain relief had been administered, the rational for this was not always clear and the effectiveness of the medicine was not recorded or monitored.

Patients told us that staff responded to requests for pain relief promptly.

Patient outcomes
The service monitored the effectiveness of care and treatment and used the findings to improve them.

The service reviewed the results from a variety of measured outcomes. For example, Hospital standardised mortality ratio (This compares mortality rates between hospitals and assists in treatments and operations that it offers to its local population). A mortality group had recently been developed in order to review mortality and take forward any learning. The minutes of these were not always clear as to the purpose and actions taken.

Pressure ulcers, falls and rates of infection were also monitored. Information on performance in areas such as falls, pressure ulcers and infections was displayed on a board outside each ward in order to inform the public. However, we looked at these boards and found the information was not always easy to read and understand due to the way they were completed. The service had been outliers’ i.e. worse results than expected for pressure ulcers and falls. However these results had improved over the last few months and the service had action plans in place to monitor these further.

Management told us that measures to improve patient outcomes are monitored on a monthly basis via mortality and morbidity meetings and divisional governance meetings. These meetings then reported into the Performance and Risk Assurance Group held monthly. This in turn reports into the Pennine Assurance Committees and Group Risk and Assurance Committee.

Additionally the Nursing Assessment and Accreditation System (NAAS) had been implemented. The system measures the quality of nursing care delivered by individuals and teams, it incorporates Essence of Care standards, key clinical indicators and each question is linked to Compassionate Care. Since its implementation the service identified that a number of wards previously rated as red (failing in a number of areas) had improved with some now rated as green (good).

We spoke with management regarding the 2016 Lung Cancer Audit and their performance in relation to access to chemotherapy, which was significantly worse than the national average. This was recognised by the service and was seen as a priority in the future. The management was confident that since their previous results this had improved.

Relative risk of readmission

**Trust Level: Elective Admissions**

![Graph showing relative risk of readmission for elective admissions](image)

Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Clinical Haematology and General Medicine patients had a lower than expected risk of readmission for elective admissions.
- Gastroenterology patients had a higher than expected risk of readmission for elective admissions.

**Trust Level: Non-Elective Admissions**
Between May 2016 and April 2017;

- All patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- General Medicine patients had a similar to expected risk of readmission for non-elective admissions.
- Infectious Diseases patients had a higher than expected risk of readmission for non-elective admissions.
- Cardiology patients had a lower than expected risk of readmission for non-elective admissions.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

*Top three specialties for specific trust based on count of activity*

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

**North Manchester General Hospital: Elective Admissions**

Between May 2016 and April 2017;

- All patients at North Manchester General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Gastroenterology patients had a higher than expected risk of readmission for elective admissions
- General Medicine and Respiratory medicine patients had a lower than expected risk of readmission for elective admissions.

**North Manchester General Hospital: Non-Elective Admissions**

Between May 2016 and April 2017;

- All patients at North Manchester General Hospital had a higher than expected risk of
readmission for non-elective admissions when compared to the England average.
- General Medicine and Infectious diseases patients had a higher than expected risk of readmission for non-elective admissions
- Cardiology patients had a lower than expected risk of readmission for non-elective admissions

Heart Failure Audit
In-hospital Care Scores

In the 2015 Heart Failure Audit the trust’s performance in relation to in-hospital care was as follows:

- Fairfield General Hospital, North Manchester General Hospital and Royal Oldham Hospital were all worse than the England and Wales average for all of the four of the standards relating to in-hospital care.
- Rochdale Infirmary was worse than the England and Wales average for three of the four standards relating to in-hospital care.

Discharge Scores

In the 2015 Heart Failure Audit the trust’s performance in relation to discharge was as follows:

- North Manchester General Hospital were all worse than the England and Wales average
for six of the seven standards relating to discharge, but better for received discharge planning.

Discharge scores – England and Wales averages

<table>
<thead>
<tr>
<th>Metric</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>ACEI on discharge</td>
<td>72.2%</td>
</tr>
<tr>
<td>ACEI/ARB on discharge</td>
<td>83.6%</td>
</tr>
<tr>
<td>Beta blocker on discharge</td>
<td>85.7%</td>
</tr>
<tr>
<td>Received discharge planning</td>
<td>87%</td>
</tr>
<tr>
<td>Referral to cardiology follow-up</td>
<td>52.2%</td>
</tr>
<tr>
<td>Referral to HF liaison service</td>
<td>57.9%</td>
</tr>
<tr>
<td>Referral to HF liaison service (LSVD only)</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

(SOURCE: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

**National Diabetes Inpatient Audit**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 43 inpatients with diabetes at North Manchester General Hospital, 79.5% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 2.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Project (MINAP)
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

Between April 2014 and March 2015, 25.1% of nSTEMI patients were admitted to a cardiac unit or ward at North Manchester General Hospital and 97% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%.

The proportion of nSTEMI patients who were referred for or had angiography at North Manchester General Hospital was 100% compared to an England average of 79%.

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
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<tr>
<td></td>
<td>nSTEMI patients seen by a cardiologist or a member of team</td>
<td>nSTEMI patients admitted to cardiac unit or ward</td>
<td>nSTEMI patients that were referred for or had angiography (incl after discharge)</td>
<td></td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>433</td>
<td>433</td>
<td>246 (246)</td>
<td></td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>235</td>
<td>235</td>
<td>151 (151)</td>
<td></td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>385</td>
<td>385</td>
<td>245 (245)</td>
<td></td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 77%, which was worse than the audit minimum standard of 90%. The 2015 figure was 92%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25.5%, this is not significantly different from the national level. The 2015 figure was 27%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 57.4%, this is significantly worse than the national level. The 2015 figure was 51%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64.9%, this is significantly worse than the national level. The 2015 figure was 70%.

The one year relative survival rate for the trust in 2016 is 34.1%, this is worse than the national aggregate.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls
The trust didn’t take part in the 2015 Audit of Inpatient Falls.

(Source: Royal College of Physicians)

Competent staff
Training that staff needed to undertake their job roles was not consistently up to date. An example of this was staff responsible for monitoring patients’ conditions via the transmission of cardiac signals to a monitor, had not received specific training or an assessment that they were competent to undertake this aspect of their job role.
Medical and nursing staff were supported through the revalidation process. Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing.

As an opportunity for development on the acute medical unit, nursing students (year one to three) were allocated to run an area of the ward with support from senior nursing staff. Medical staff would discuss care and treatment directly with the students. A learning log and individual objectives for competencies was in place for each of the students in order to help them develop leadership skills.

However, two new staff members we spoke with told us they had not been allocated a mentor to ensure orientation to their job role. Additionally they had not had opportunity to attend any specific training events in the last few months.

Locum doctors told us they were able to access the same training as permanent staff and spoke positively about the opportunities available to develop their knowledge and skills. Senior managers informed us that they encouraged and supported locum staff to access the training in order to maintain their skills and provide a good quality of medical care.

**Appraisal rates**

Although the service did not yet meet its own targets for appraisals there had been improvements since the last inspection. Staff stated that they felt more supported to attend training and appraisals were more effective in maintaining their skills.

Staff told us that they had their learning needs identified and assessed during their annual appraisal. Staff told us that the appraisal process was valuable and provided opportunity for them to discuss their personal aims as well as mandatory training.

Between June 2016 and May 2017, 55% of staff working within medicine at the trust had received an appraisal compared to a trust target of 90%.

The 55% appraisal rate applies to nursing and midwifery registered, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At North Manchester General Hospital 58% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients.

All staff described effective working between consultants, nurses and allied health professional staff. We observed a board round which incorporated staff from a variety of disciplines. As part of the meeting, they discussed the plans of care and treatment for each patient and made sure that there was a joined up approach in providing treatment. This included referrals to social support and care support once the patient was discharged from the service.

Staff on the respiratory ward said that they had good support from the community respiratory team and that they worked well together to support patients following discharge and if patients needed to be readmitted.

During focus groups Allied Health Professionals (AHPs) said they often felt overlooked. This is something the management was aware of and have put a plan in place to create AHP leads.

There was evidence of partnership working with the local mental health trust to deliver services for those patients with mental health, drug or alcohol issues. The rapid assessment, interface and
discharge (RAID) team visited inpatients on medical wards to provide assessment, advice and intervention as needed.

**Seven-day services**

There was access to input from specialist medical teams at weekends such as cardiology. Emergency endoscopy was available 24 hours a day to manage gastrointestinal bleeding. The psychiatric liaison service was available 24 hours a day.

There was a pacing room on the cardiac care unit (CCU). This was available for emergency use 24 hours a day as well as providing planned care to patients.

Occupational therapy was provided at weekends although this could be limited to mornings only. Physiotherapy was provided for patients with respiratory problems at weekends and to assist in patient discharge.

The ambulatory care unit previously called the Manchester treatment centre was open seven days a week from 8am to 9pm. Overnight stays had ceased on this unit following the last inspection when it was identified that this did not meet patients’ needs.

**Health Promotion**

We observed that during our inspection all staff patients and visitors were offered free of charge a flu vaccination.

On the wards there was information available for patients to take with them that assisted them in maintaining their own health.

On the discharge lounge patients were informed of the ways to maintain their health after discharge.

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

The arrangements for patients’ rights to be protected under the Mental Health Act 1983 and the Mental Capacity Act 2005 were not effective.

We looked at 18 records for patients highlighted to us by staff as lacking capacity or having fluctuating capacity. The mental capacity assessments we reviewed varied in quality. Some were correctly completed and looked at each decision needed specifically using the two stage process (Can the person make this decision at this time). We did see capacity assessments that were utilised as a “blanket” approach as they determined a lack of capacity but did not outline the decision that was needed and staff utilised these for all decisions made.

Documentation of best interest discussions was not available in the records. This was particularly notable in relation to do not attempt cardio-pulmonary resuscitation (DNACPR). We looked at six DNACPR and saw that these were not consistently completed. One stated ‘to be discussed with family later’ but had been implemented regardless of that discussion, bypassing the need to have a best interest discussion with those closest to the patient. We saw in two patient records that the “do not resuscitate” documentation was up to date.

Some staff we spoke with had an overview of mental capacity assessments and the importance of these. However four staff we spoke with were not aware of the need for decisions to be specific nor of the need to ascertain if there were times or occasions when a patient’s capacity was sufficient.

There was guidance on the hospital intranet on best interest decisions and the Mental Capacity Act including a summary of actions.

The use of deprivation of liberty safeguarding order (DoLS) for patients who lacked the capacity to consent to treatment and were required to remain in the hospital were appropriately applied for
and correctly implemented. There was continual reassessment of Deprivation of Liberty Safeguards for patients as they moved through the hospital.

**Mental Capacity Act and Deprivation of Liberty training completion**

Training for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was part of the adult safe-guarding training.

Data for this metric was not provided.

*(Source: Trust Routine Provider Information Return (RPIR) P40 – Statutory and Mandatory Training)*

### Is the service caring?

**Compassionate care**

Staff cared for patients with compassion.

Overall patients and relatives we spoke with gave positive feedback about the care and support they received from staff and praised them for their kindness. They thought that staff spoke to them with kindness and often “went the extra mile” in order to make sure that patients’ needs were met.

Staff demonstrated that they were aware of and responded to people’s needs, backgrounds and spiritual needs. We observed staff interacting with patients with compassion and treating them with respect.

However, we observed a handover in which the discussions and written handover record did not consistently maintain the dignity of patients and their individual needs. This was discussed with the Lead Nurse at the inspection.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

On most of the wards we visited there was a quiet room that relatives could use if needed. A chaplaincy and spiritual care team was available to patients and relatives 24 hours every day. A Christian chapel was available during the daytime and a Muslim prayer room with a women’s area was also open 24 hours a day. Additionally facilities were available to patients of a Jewish faith 24 hours a day.

Patients reported that if they became upset or distressed, staff were quick to respond and give reassurance.

There was limited information such as talking therapies that could be accessed for patients with a life changing condition. Staff said that this could be arranged if patients requested it but could not recall any patients asking for it. They were unsure whether patients were informed of this service.

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

Staff did not consistently involved patients and those close to them in decisions about their care and treatment.

We saw some evidence in patients records of discussions with relatives although this was not always evident. It was not clear in records as to what information had been given to patients regarding their care and treatment. Discussions with three relatives and two patients indicated their remained inconsistencies in how much they were involved in decision making regarding care and treatment.
We saw that in one example conflicting views and advice resulted in an unclear plan of care for a patient. When we reviewed the patients’ records there were no documented discussions with relatives regarding a plan of care and no clear plan had been set prior to transfer from the ward to the coronary care unit. This was identified and actioned quickly following an incident being raised by the ward manager.

**Friends and Family test performance**

Between August 2016 and July 2017 the Friends and Family Test response rate for Medicine at the trust was 22% which was slightly worse than the England average of 25%.

![Graph showing Friends and Family Test performance](image)

A breakdown of percentage recommended by site and ward is shown below:

<table>
<thead>
<tr>
<th>Service Delivery to meet the needs of local people</th>
</tr>
</thead>
</table>

(Source: NHS England Friends and Family Test)

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The service did not consistently plan and provide services in a way that met the needs of local people.

Patients with complex needs such as learning disability, dementia or a mental health need were not consistently identified in order for staff to be fully aware of the need to provide additional person-centred support. There was some identification used on the front of records and through using coloured wrist bands. However, this was not consistently utilised. As a result this meant that services did not always meet the needs of patients with a learning disability or cognitive impairment.

The environment throughout the service was not sufficiently adapted to assist people with complex needs or cognitive impairment to easily deliver care in a way that met their needs and promoted equality. Although the service had plans to adapt the environment to be more person-centred this had not yet started. Throughout the service the signage was confusing with many of the medical wards identified by different names than the ward was known as. This was also reflected in the service’s website which identified wards by different names. This made navigating throughout the service and between different wards difficult.

The acute medical unit had recently been increased in size and there were plans to further expand the size of the unit. Senior management said this was planned in order to meet the needs of the wider community.

However, during our inspection there were two patients admitted to the acute medical unit placed in single occupancy rooms as they were at the end of their lives. The unit was very busy with care and treatment provided to a wide variety of patients. Staff spoken with and a family member were concerned that as the unit was busy and occasionally noisy, this was not a suitable place for them to be.

The service was part of the regional healthier together and devolution Manchester programmes of work to improve health services for local people.

**Average length of stay**

**Trust Level: Elective Average Length of Stay**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>8.0</td>
<td>5.8</td>
</tr>
<tr>
<td>General Medicine</td>
<td>2.4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Between June 2016 and May 2017;

- The average length of stay for all elective patients at the trust was 5.1 days, which is higher than the England average of 4.2 days.
- Average length of stay for Gastroenterology and General Medicine elective patients is lower than the England average.
- Average length of stay for Clinical Haematology elective patients is higher than the England average.

**Trust Level: Non-Elective Average Length of Stay**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at the trust was 5.0 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine and Infectious diseases non-elective patients is lower than the England average.
- Average length of stay for Cardiology non-elective patients is higher than the England average.

**North Manchester General Hospital: Elective Average Length of Stay**

Between June 2016 and May 2017;

- The average length of stay for all elective patients at North Manchester General Hospital was 1.8 days, which is lower than the England average of 4.2 days.
- Average length of stay for Gastroenterology, Respiratory medicine and General Medicine elective patients is lower than the England average.

**North Manchester General Hospital: Non-Elective Average Length of Stay**

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at North Manchester General Hospital was 4.8 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine and Infectious diseases non-elective patients is lower than the England average.
- Average length of stay for Cardiology non-elective patients is higher than the England average.
Meeting people’s individual needs

The service did not consistently take into account patients’ individual needs.

We were informed by patients, staff and management of the ambulatory unit that patients were receiving intimate procedures in an areas where beds, although separated by a curtain were close together. This could potentially compromise patients’ dignity and often their personal preferences. During our inspection we confirmed that intimate conversations could be easily overhead by other patients.

Patients with complex needs such as a learning disability, dementia or a mental health needs were not always identified on admission in order for staff to provide additional person centred support. Staff showed us that alerts could be put onto the online records system but these were not immediately apparent and staff were required to actively check for alerts. Although there were coloured wrist bands available, in some cases this would mean patients would end up wearing several different coloured wrist bands and the idea to make this noticeable to alert staff would be less obvious.

There was limited information contained within records to ensure that patients’ individual needs and wishes were identified and taken into account in planning and delivering the care they were to receive. This included a lack of appropriate care plans, lack of flexibility in medicines management and arrangements to monitor food and drink.

Senior management had recognised that the environment on the ambulatory care unit was not suitable for patients living with dementia or a cognitive impairment. This was identified at the previous inspection. Staff spoken with in the unit stated that despite working with the dementia nurse consultant to look at ways to make the environment more dementia friendly this had not improved the environment.

We were told that, “reminiscence” electronic tablets were in use on some wards. These tablets allowed staff to set up individual activities such as bingo and music and also to provide information about life history and personal preferences. We spoke with staff regarding these. They stated that they were aware that they were available but rarely had time to provide this support to patients. During our inspection there was no occasion when we saw these in use.

The most requested languages for written information were Urdu, Punjabi, Bangla and Polish. Staff told us they had access to face to face interpreters if required. However, they also stated that they had rarely used this facility as family often acted informally as interpreters. This is not best practice as family translations may not be suitable.

We observed a handover in which the information given was centred on patients’ health conditions. There was limited discussion around patient choices or preferences. However the manager of the ward did add into the handover and highlighted patients’ individual needs and encouraged a more person centred approach to the care agreed.

There was an open visiting policy in place. Patients and their relatives spoke positively about this. Staff also reported that there had been a positive impact on patient care.

Access and flow

People could not consistently access the service when they needed it

Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).
Medical outliers were cared for by a dedicated consultant and junior doctor team. Daily ward rounds were held for outliers. We saw that on every ward we attended there was a minimum of one patient who was not situated in a bed better suited to their needs.

Patients waited on the Acute Medical Unit (AMU) for longer than necessary due to bed shortages. Two patients had been waiting for a medical speciality bed for over three days. Staff told us that there had been some instances where patients had been transferred to other local hospitals for an angiography procedure and when the patient returned, the bed had been given away. This was identified as an issue at the previous inspection.

Staff on the cardiac care unit (CCU) told us that there was often a wait for beds on other medical wards. On the day we visited this unit, one patient no longer required the level of care provided on CCU and were awaiting a medical bed. This meant that patients that needed admitting to CCU may not have been able to access the care they needed in a timely way.

Patients were moved onto the medical discharge ward when they were medically fit for discharge but were not yet ready to be discharged as they had ongoing therapy or social work needs. Discharge plans were discussed during nursing handovers. Staff told us there were often long delays for packages of care to be arranged or there were delays whilst patients waited for medicines or ambulance transport.

Patients could be referred to the ambulatory unit by GPs. Patients received investigations and treatment here and were discharged without a need to be admitted to the hospital. If discharge was not appropriate, a referral would be made to AMU for admission to the hospital.

Patients typically waited at the centre for two to three hours. Staff at the ambulatory unit told us that the centre was not always used appropriately. They gave an example of although rare the ambulatory unit was sometimes used for patients who were awaiting beds on medical wards. Staff also told us that in the past, the ambulatory unit had been used as a ward area during times of bed pressure. However they confirmed that after the last inspection this practice had ceased and patients no longer stayed overnight.

Managers told us that approximately 20% of medical beds across the trust were filled with delayed discharges.

Referral to treatment (percentage within 18 weeks) - admitted performance

Between August 2016 and July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine has remained fairly consistent and has been in line with or better than the England average for 10 of the 12 months in the period (September 2016 and February 2017 slightly below the England average).

As of July 2017 98% of patients were treated within 18 weeks compared to the England average of 90%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
A breakdown of referral to treatment rates for Medicine broken down by specialty is below. Of these, four of the specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.2%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moves per admission**

Records available indicated that patients were moved several times during their stay in hospital. Information from the trust showed that between June 2016 and May 2017, 2364 patients were moved overnight. During the inspection we saw that at least three people with a diagnosis of dementia were moved late at night and early in the morning. This was an increase in the amount of overnight moves since the previous inspection.

We saw that for six different patients the SBAR (Situation, Background, Assessment and Recommendation) used to communicate important information between wards was either incomplete or not available. As a result patients arrived at the new ward without accurate information that staff could use to meet individual needs.

Bed management meetings were held four times a day to discuss current bed state and predicted bed requirements. There was an escalation policy in place for use in times of additional pressure on the service. Staff were able to explain how they would escalate issues surrounding capacity to managers and managers told us that these issues would be discussed at bed meetings. Bed meetings provided the opportunity for managers to locate available beds for patients who required admittance to the hospital and initiate the escalation policy if necessary to do so.

Between June 2016 and May 2017, overall at the trust, 60% of individuals did not move wards during their admission, and 40% moved once or more.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of individuals not moving wards</th>
<th>% of individuals with one or more ward moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Manchester General Hospital</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Rochdale Infirmary</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Return – Bed Moves)

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Staff and patients told us they felt confident to raise any concerns and their opinions would be listened to.

Complaints were investigated and completed in a timely way with the learning discussed and changes to the service provided influenced by the findings of the complaints.

Senior managers told us that complaints were discussed every week and a decision was made if the complaint needed to be escalated for further investigation. They told us that the delayed
response times for complaints had improved as there were no outstanding complaints at the time of the inspection. This was an improvement from the previous inspection.

Staff spoken with knew how to deal with complaints and concerns which were investigated by a manager who shared lessons with all staff. These were discussed at team meetings and handovers.

Formal complaints could be raised through the Patient Advice and Liaison Service (PALS) and information on how to contact PALS was displayed throughout the service. Further information and the trust complaints handling policy was available to the public via the trust website.

**Summary of complaints**

Between June 2016 and May 2017 there were 166 complaints about Medicine (20.4% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 52 complaints still open and yet to be completed.

There were 39 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 23%.

- North Manchester General Hospital: There were 53 complaints (31.9%)

There was one complaint relating to all sites.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing sustainable care.

Since our last inspection the trust had restructured to form Care Organisations which covered each location and enabled leaders to have clearer oversight of their respective services. The clinical leaders we spoke with were positive about the changes to management structures and the move to Care Organisations but accepted that this model of working was still in its infancy.

Staff we spoke with said that there had been an improvement in management since January 2017 and that managers were now more visible and more approachable. Senior managers including the medical director did walk rounds of the wards every other week and monthly walk rounds at night.

Ward staff were not always aware of who their clinical lead was within the Care Organisation but the majority of staff were aware of changes that had been made to the leadership structure. Staff told us they felt positive about the changes made although there had been a lot of changes all made at once.

The director of nursing spent time on the wards to discover what the issues were for the staff. Staff acknowledged that it was a good way to communicate with them. Patients commented that they had seen senior staff on the wards.

Clinical services were clinically led and clinically driven by the staff to improve patient outcomes.

There had been a leadership programme for ward managers. A senior nurse said that she had completed the programme which had been useful in her development. There had also been leadership programmes for senior staff.
Specialist nurses had good links across all four hospital sites and held bi-monthly meetings with nurse consultants.

Staff told us that systems and processes between the four trust sites were different and this could be frustrating at times.

The directors and clinical leads that we met with were passionate and enthusiastic about their roles. They were aware of the challenges to improvement and were looking at ways to address them.

**Vision and Strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Staff understood and put this into practice.

The strategy had been developed through engagement sessions with staff. There had been three separate days of staff engagement and 1000 voice events. Staff we spoke with were aware of the vision and strategy for the division of the care organisation.

The services vision was to be ‘A leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.’

Values were outlined as: quality driven, responsible and compassionate. With priorities of quality improvement, sustainability, integration and compliance with mandatory standards.

Throughout the service we saw posters outlining the vision and strategy and the progress the service was making to achieve its vision. Staff were aware of the vision and strategy and the aims of the service to achieve this.

Since March 2016 Salford Royal had taken over management of Pennine Acute Trust. The leaders we spoke to were positive about learning which could be taken from Salford Royal but were keen to maintain a separate identity.

The trust provided us with a copy of their Quality Improvement Strategy and we were encouraged to see evidence of the projects outlined in the strategy being implemented on the wards. Examples of projects included; end PJ paralysis, introduction of EWS, reliable ward rounds, VTE assessments and redesign of MAU to include frailty.

The senior management and staff expressed some concerns as they were unclear as to the future of the service and if it would continue to operate in the same manner.

**Culture**

A consistent positive culture that supported and valued staff, creating a sense of common purpose based on shared values was not in place.

Although staff stated there had been significant improvements in the culture that had previously been seen, it was acknowledged by managers and staff that this needed to be developed further. There were still occasions when staff said the culture could feel more blame than supportive. However, this was acknowledged as rare in comparison to previous years.

There were processes in place for the application of the duty of candour and for the service to be open and transparent. We saw that in the investigation of incidents the duty of candour had been applied appropriately.

There was an occupational health service for staff that included psychological support if necessary. The service was in house and staff could self-refer or be referred by their manager. Staff spoken with said that they knew this facility was available but that it was not always
convenient for them to access and there were concerns that it was not distant enough from the trust to ensure that confidentiality was fully maintained.

There was an equality and diversity lead for the division and one for the hospital to promote equality and diversity issues. Managers said that there was a wide diversity of staff across the professions and grades of the hospital. However the staff survey results highlighted an inequality in the support and promotion of BME staff. Black and Minority Ethnic (BME) is the terminology normally used in the UK to describe people of non-white descent. A BME staff network had been put into place which was to be mentored by members of the Board of Directors.

While we found a mostly positive culture throughout the hospital some staff spoken with felt the culture was not supportive. Some staff also felt that they were not given the correct assistance in order to be able to safely complete their duties. Some staff reported that they were undertaking responsibilities beyond their grade and on occasions felt unsupported by managers.

**Governance**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There were three care organisations in the trust each care organisation had a directorate based leadership team comprising of the managing director and supported by the medical director and the director of nursing. Under this structure was the division of integrated care which had a divisional managing director, a divisional director of nursing and a divisional clinical director. There was clear accountability and objectives for the directorate that were set by the director team and the board. Under the director leadership structure was the site management structure which was; the general and specialist medicine directorate with a directorate manager and clinical directors. At all levels of management there were clinicians to support the strategic and operational delivery of services.

The management structure had been in place since January 2017 and there had been an improvement in safety performance, staffing (including medical staffing) and the standardised hospital mortality rates since then. Staff, including consultants said that things had improved since the new management structure but that there was still work to do. There was a quality dashboard for the hospital which included a number of indicators and targets for safe and responsive care. The dashboard showed previous and current performance and indicated trends with colour coding for performance.

The service had implemented the nursing assessment and accreditation system (NAAS). This covered a number of areas including nutrition, tissue viability, falls, medicines, care plans, patient experience and mandatory training. Wards were inspected and graded red, amber or green. Action plans were put in place as appropriate. Ward managers said that this had improved patient safety on the wards. Staff told us that quality improvement was an agenda item at each of their staff meetings.

**Management of risk, issues and performance**

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not consistent.

The management team did not have a clear oversight of all the risks within medical services. For example, no actions had been taken to mitigate risks in relation to infection control in the ambulatory unit or its unsuitability to meet the needs of patients. This had been identified at a previous inspection. Other risks not identified or actioned included the lack of training and competency of staff undertaking continuous cardiac monitoring, also identified at a previous inspection, inconsistent record keeping and a lack of robust management regarding maintaining patient rights.
Staff said that they understood the importance of audit and governance, but felt that too much time was taken away from caring for patients and this was frequently about ticking boxes rather than caring for patients.

NAAS results recognised the need for improvement to patient care but in some cases the results showed that improvements were not always sustainable or that improvements sometimes did not occur.

The division of medicine had a divisional governance lead. Quality and performance meetings were held within the division and in turn this was fed up to the trust Executive Quality and Patient Experience Governance Committee. Divisional governance leads met together to share learning across divisions.

The medical division had risk management and quality measures in place to improve patient care, safety and outcomes. There was a risk register for the service and directors were able to give examples of risks listed as high on the register. They were also able to describe how these risks were being mitigated and how this was being monitored for improvement.

**Information Management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff and managers confirmed that a secure login was required that was unique to the individual before they could access confidential information. Staff also confirmed that they had been given guidance on information governance and maintaining the security of the system such as not opening emails that were suspicious.

Staff described the IT systems at the hospital as slow and not fit for purpose. Results from tests could take up to an hour to download in order that staff could see the results. Additionally there was a variety of different systems that did not talk to each other.

The service has two IT failures when the IT systems failed for a period of time in the last 12 months. These had emergency plans in place which senior management stated had worked appropriately and had not had a major impact on the service provided.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There was a dashboard for staff engagement and a staff survey was completed every three months.

There were open and honest care boards including “you said, we did” information displayed throughout the service. These boards displayed comments received from patients and planned or actual changes made as a result.

There were display boards highlighting relevant information such as the vision and strategy and key members of the management team in order to identify them to staff and public.

The services website outlined opportunities to contact the trust and express opinions and supplied information on the services and hospitals.

Patients were involved in patient led assessments of the care environment (PLACE) visits and were invited to listening into action focus groups throughout the year.

Response rates to the friends and family in medicine were 22% which was slightly worse than the England average of 25%. This represented a reduction from previous results.

**Learning, continuous improvement and innovation**
The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The hospital had appointed a mortality lead who had administration support. The hospital were following the guidance from the National Quality Board learning from deaths. The frequency of mortality meetings had improved and there was a meeting every month instead of every two months. Previously each speciality was discussed in turn but cases were discussed as they arose.

The structure of the meetings had changed and there were joint meetings with urgent and emergency care with a focus on patient care in the first 24 hours and was reflective of the patient journey. Minutes were shared for more joined up learning and shared across the specialities. There was also sharing of information about patients’ pre-critical care.

There had been a multidisciplinary review of mortality and morbidity which included representation from senior allied health professionals, junior doctors, assistant directors, consultants, GP’s with links into community services and families via the bereavement nurse.

There was facilitated teaching in forums, for example, mortality matters in foundation teaching by the mortality lead. The end of life team did teaching sessions in acute medicine and for medical staff. There were also teaching sessions by the coroner and a presentation by family regarding resuscitation decisions and discussions.

Managers encouraged innovation and shared good practice upwards so other divisions could benefit. Examples included students supported to develop leadership skills and training of pharmacy staff to administer medicines freeing up staff to provide care and treatment.
Surgery

Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all trust services)
North Manchester General Hospital provides general surgery, urology, breast, oral-maxilla-facial, dental, head & neck, and orthopaedic trauma and elective surgical services in a mixture of longer stay and short-stay (6 day) wards.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

The trust had 54,841 surgical admissions between June 2016 and May 2017. Emergency admissions accounted 15,857 (28.9%), 30,265 (55.2%) were day case, and the remaining 8,719 (15.9%) were elective.

(Source: CQC Insight)

Is the service safe?

Mandatory training

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Surgery & Anaesthesia Division are shown below:

Medical and dental staff in the Surgery & Anaesthesia division met the 90% target for mandatory training compliance for two modules only (advanced paediatric life support (100%) and advanced life support (91%)).

Basic life support training had the lowest compliance levels with only 59% of eligible medical and dental staff having been trained.
Nursing and midwifery staff in the Surgery & Anaesthesia division met the 90% target for mandatory training compliance in four modules, achieving 100% compliance in three (advanced life support, paediatric immediate life support and moving and handling (non-patients)). Immediate life support training had the lowest compliance levels with only 31% of eligible nursing and midwifery staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training was available via online courses as well as face-to-face and staff reported this was easy to access. The compliance summary for the division of surgery at North Manchester General Hospital showed at the time of our inspection a combined compliance of 83% with core training and a combined compliance of 73% with essential job-related training. Staff told us they completed Basic Life Support training rather than Advanced Life Support training as indicated in the data. From a total of 643 staff who required Basic Life Support training in the division of surgery at North Manchester General Hospital 498 had attended, this is a compliance rate of 77.5%. One member of staff had received Immediate Life Support training and no staff had received Advanced Life Support training.

Major incident awareness and training

North Manchester General Hospital had a documented major incident plan which listed key risks that could affect the delivery of services. Staff we spoke with were aware of their role.

Major incident training completion rates
Data for this metric was not provided.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
**Safeguarding**

Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to and staff demonstrated how to access them. Staff knew how to obtain advice and support from the safeguarding team and could describe the process they would use to escalate a safeguarding concern.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in the division of Surgery and Anaesthesia is shown below:

![Safeguarding training completion by module (medical & dental staff)](image)

The 90% target was only met for one of the safeguarding modules (level 2 adults) by medical and dental staff in the Surgery & Anaesthesia division at the trust. The target for level 2 children’s training compliance was almost achieved with 87.4% compliance which equated to 311 of the 356 eligible staff members completing the training.

Compliance for level 3 adults was the lowest, with only 161 of the 210 eligible staff members completing the training.

Nursing and midwifery staff in the Surgery & Anaesthesia division exceeded the 90% completion target for both level 2 adults and children’s safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.
(Source: Trust Provider Information Request P18)

The service did not meet the target for level 3 safeguarding children however, we only inspected the surgical service for adults at North Manchester General Hospital.

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean however, we observed inconsistent completion of cleaning checklists where they were present.

Adequate hand washing facilities were available and hand gel dispensers were positioned at multiple areas throughout wards and departments with the exception of the discharge lounge in the day surgery unit which had no handwashing sink. Staff were observed following current infection prevention and control guidelines such as the ‘bare below the elbow’ policy. Correct scrub procedures were observed in theatres. Personal protective equipment such as aprons and gloves was readily available. Patients and relatives told us they had observed staff washing their hands and using hand gel regularly.

Within the day surgery department curtains were used to screen patients in the recovery areas. All curtains were labelled to identify when they had been changed. Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and in all areas we visited sharps bins were noted to have been signed and dated when assembled.

Infection prevention formed part of the Trusts mandatory training programme. The compliance summary for the Division of Surgery at North Manchester General Hospital showed at the time of our inspection 68% of staff had attended patient related infection prevention training against a target of 90%.

**Environment and equipment**

The environment in main theatres was old and displaying signs of wear and tear. Plaster was exposed on the walls in the main corridor, exposed wood was observed on the doors to theatre one and theatre one anaesthetic room and a hole was observed in the flooring in front of the nurses station in the recovery area. Theatres one and two were also observed to have open access to a sluice area. We requested data from the trust regarding surgical site infection rates at North Manchester General Hospital, however this was not available.

Documents requested from the hospital confirmed an annual ventilation inspection had taken place in all 13 theatres. Hospital redevelopment and estates were recorded as a risk on the trust corporate risk register.

Emergency resuscitation equipment was in place, trolleys we reviewed were visibly clean and daily and weekly checklists completed. Visible dust was observed on the difficult intubation trolley in general theatre and the items on the checklist did not correspond to the contents. This was raised with staff during the inspection.

Safety testing was in place for equipment however not all of the equipment we observed had stickers with dates confirming that maintenance checks had been completed. Staff attention was brought to equipment observed as past the due date for servicing for example fans in the day surgery unit.

Data from the trust showed that 56% of equipment within the theatres was in date with Electronic and Biomedical Engineering servicing.

An equipment co-ordinator was available to source additional items not stored on wards such as bariatric commodes or chairs and we observed equipment required for patients discharge discussed at daily multi-disciplinary team meetings on ward 15.

**Assessing and responding to patient risk**

Records reviewed indicated that the condition of patients was monitored and deterioration was appropriately escalated for medical review to ensure appropriate care and treatment.
The Malnutrition Universal Screening Tool (MUST) provides an assessment of a patient’s nutritional status on admission and assesses nutritional risk. We observed this tool completed in six of the 10 records we reviewed. Staff told us that any patient considered at risk following completion of the MUST assessment would be referred to a dietician.

Sepsis 6 care bundle was in use for screening and managing sepsis and training had been delivered to staff in relation to sepsis. Data provided by the trust showed compliance rates ranged from 13% on ward 15 to 83% on ward C3 against a target of 30%.

Any patient with a planned elective surgical procedure routinely attended an appointment for a preoperative assessment. This identified risks prior to surgery and included lifestyle information and assessment of any existing medical conditions as well as infection screening and post-operative planning. Any patient who did not proceed to surgery within 12 weeks of attendance required the full assessment process to be repeated. Information regarding primary risks and co-existing conditions was communicated electronically to the anaesthetist and medical staff and distributed to theatre staff preoperatively. We observed alert information discussed in the theatre safety huddle prior to commencement of the operating list.

During our inspection we observed theatre processes including implementation of the World Health Organisation (WHO) Surgical Safety Checklist Five Steps to Safer Surgery. Despite data from the trust indicating that between April 2016 and June 2017 compliance with the WHO Checklist ranged from 99% to 100%, on several occasions it was noted that not all elements of the checklist were observed including no formal sign in, sign in was not verbalised and not all staff were in theatre for the sign out. The implementation of the checklist was not observed as an interactive process and on two occasions there was no silent focus while the checklist was completed. We discussed this with managers who acknowledged non-compliance and lack of engagement with the process and advised that the WHO Checklist was to be re-launched across the trust the following week. Deficiencies in implementation of the WHO Checklist were also identified in two incidents two months prior to our inspection when two patients were anaesthetised in theatre before it was discovered there was no consent form for the planned procedure.

Current standards from the Association for Perioperative Practice (AfPP) state that at least one member of staff on duty in the theatre recovery area should have completed Advanced Life Support (ALS) training. Main theatre recovery did not have an ALS trained member of staff on duty on the day of our inspection, this was confirmed by the team leader who advised that no recovery staff had attended ALS training. Following the inspection, the trust told us that recovery staff undertake ILS training and the roster is organised such that there are always ILS trained staff in recovery, with paediatric ILS trained staff present on days when children are cared for post-operatively. However, no additional evidence was provided to demonstrate compliance.

At our last inspection the trust confirmed there were three occasions were patients were cared for in theatre recovery in the previous 12 months. Data from the trust during this inspection confirmed that three patients were stabilised in theatre recovery during the night and two patients experienced a delayed discharge from recovery during the day awaiting a level 2 or level 3 care bed in the last 6 months.

**Nurse staffing**

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>602.14</td>
<td>661.36</td>
</tr>
<tr>
<td>January 17</td>
<td>602.18</td>
<td>659.63</td>
</tr>
</tbody>
</table>
Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 8.9% for nursing and midwifery staff in Surgery;

- North Manchester General Hospital: 11.4%

(Source: Routine Provider Information Request (RPIR) – P17 Vacancies)

Turnover rates

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing and midwifery staff in Surgery;

- North Manchester General Hospital: 1.0%

(Source: Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.4% for nursing and midwifery staff in Surgery, which is above the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 4.9%

(Source: Routine Provider Information Request (RPIR) – P19 Sickness)

All theatres were staffed as per the Association for Perioperative Practice (AfPP) recommendations.

The expected and actual staffing levels were displayed on ‘Open and Honest’ notice boards at the entrance to wards and departments in the surgical directorate. Both staff and managers told us that ward staffing remained a challenge and was recognised on the divisional risk register. However, staff we spoke with told us this had improved and gaps in off duty were often filled with regular bank and agency staff.

No recognised acuity tool was in use to assess staffing needs on the surgical wards, staffing was determined using the Safer Staffing tool. This meant that staffing levels were based on numbers of patients rather than their level of care need. The target for compliance with the Safer Staffing metric was 95%. Information obtained from Committees in Common Papers indicated that in August 2017 the average fill rate for registered nurses in the surgical directorate ranged from 68.6% to 128.4% for day shifts and 77.2% to 104.7% for night shifts and in September 2017 ranged from 68.2% to 125.2% for day shifts and 79.7% to 106.7% for night shifts.

The average fill rate for care staff in August 2017 ranged from 89.7% to 144.6% for day shifts and 100% to 238.5% for night shifts and in September 2017 from 89.2% to 144.9% for day shifts and 101.3% to 188.2% for night shifts.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Between May 2017 and October 2017 there were 30 incidents reported as a result of staffing related issues including level, skill mix and performance.

Managers advised a number of initiatives had been implemented to support staffing levels such as increasing the number of band 6 posts, use of flexible working practices, encouraging students during training to return to the directorate and development of the assistant practitioner role.

We observed a nurse handover on ward I5 where three different handover styles were being trialled at the time of our inspection. We observed a handover that took place at the desk in a patient bay and involved reviewing all patient charts including early warning scores and observations. Staff explained this was to promote compliance with record keeping however, details of patients name, age, diagnosis, investigations, plan of care and social care involvement were discussed in close proximity to patients beds. We raised concerns regarding the lack of privacy and confidentiality with the ward manager during our inspection.

**Medical staffing**

The trust has reported the following planned and actual staffing figures for medical and dental staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>290.65</td>
<td>313.53</td>
</tr>
<tr>
<td>January 17</td>
<td>292.65</td>
<td>316.13</td>
</tr>
<tr>
<td>February 17</td>
<td>296.65</td>
<td>316.18</td>
</tr>
<tr>
<td>March 17</td>
<td>297.65</td>
<td>315.80</td>
</tr>
<tr>
<td>April 17</td>
<td>297.15</td>
<td>315.80</td>
</tr>
<tr>
<td>May 17</td>
<td>293.25</td>
<td>315.80</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.1% for medical and dental staff in Surgery;

- North Manchester General Hospital: 10.7%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017 the trust reported an average turnover rate of 1.5% for medical staff in Surgery;

- North Manchester General Hospital: 2.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
Between June 2016 and May 2017, the trust reported an average sickness rate of 1.7% for medical staff in Surgery which is better than the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average whilst the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for whole time equivalent staff working at The Pennine Acute Hospitals NHS Trust

![Staffing skill mix chart]

(Source: NHS Digital Workforce Statistics)

Junior medical staff told us they felt supported and senior review of patients occurred on a regular basis. On call consultants were identified however staff told us while they could always be contacted, they were they were not always in the hospital during the week as elective surgery took place on other sites. Out of hours there were processes in place for consultant cover. General surgery and colorectal surgery had non-resident on call consultants, trauma and orthopaedics had non-resident on call with an on site presence 08:00-18:00 Saturday and Sunday.

Records

Patient records were stored in trolleys with key code locks. We looked at 10 complete sets of patient records including risk assessment and observation charts. All records were signed and dated, diagnosis and management plans were present within medical records and evidence of multi-disciplinary working was documented as required.

Risk assessments using the Malnutrition Universal Screening Tool were completed in six records, falls assessments documented in seven records and Early Warning Scores used to record observations and identify signs of deterioration were completed correctly in all 10 records.

Staff in the day surgery unit told us how the Traffic Light Passport document was used for patients with additional needs. The Traffic Light Passport provides staff with important additional information about a patient including any reasonable adjustments that maybe required to ensure care is tailored to individual needs.
Medicines

Medicines were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation and daily pharmacy support was available. Controlled drugs were stored securely and accurate records maintained in accordance with 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. Maximum and minimum temperatures had been recorded in accordance with national guidance however, temperatures had been recorded outside the recommended range. Room temperatures where medicines were stored were recorded daily, and we found that these were higher than the recommended limits. On the Surgical Triage Unit documentation indicated this had been escalated to pharmacy but no remedial action was evident.

Prescriptions were completed electronically and of the six prescription charts reviewed all had allergies documented, antibiotics prescribed as per guidelines and venous thromboembolism prophylaxis if indicated.

Staff on the Surgical Triage Unit told us that the Accident and Emergency department did not use the electronic prescribing system and therefore patients could arrive on the unit requiring analgesia without an electronic prescription. This meant that patients would have to wait for pain relieving medication if a doctor was not immediately available to complete a prescription. Due to the different systems used, patients who had been seen in the Accident and Emergency department by a surgical doctor and had an electronic prescription commenced may also arrive on the unit having missed doses of medication however no incidents were recorded in the Surgical Triage Unit in the six months prior to our inspection. To mitigate this issue one member of staff was planning to undertake the non-medical prescribing course.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported one incident classified as a never event for Surgery.

- 9th January 2017, Fairfield General Hospital (STEIS: 2017/888/REX) An anaesthetic block was applied to the wrong location.

(Source: Strategic Executive Information System (STEIS))

No never events were recorded at North Manchester General Hospital during this period however, senior managers advised that a never event was being declared by the surgical directorate at North Manchester General Hospital on the first day of our inspection.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 24 serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 7 slips/trips/falls meeting SI criteria (29% of total incidents).
- 5 all other categories (21% of total incidents).
- 3 surgical/invasive procedure incidents meeting SI criteria.
• 3 treatment delay meeting SI criteria
• 3 pressure ulcer meeting SI criteria
• 3 sub-optimal care of the deteriorating patient meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

We reviewed the investigation reports from two serious incidents at North Manchester General Hospital and found lessons learned were identified in both cases and action plans initiated to reduce the likelihood of incidents being repeated.

A new electronic incident reporting system had been introduced in August 2017. Not all staff we spoke with reported receiving training on the new system however, those that had reported an incident had found it easy to use. Incident reporting was variable across the surgical directorate, some staff advised they regularly reported incidents while others had not done so for a considerable time. Staff were aware of the types of incidents they would report and lessons learnt from incidents was shared with staff in weekly bulletins and discussed in team meetings and safety huddles. Lessons learnt from incidents on other trust sites was not as effective, senior managers told us of an improving culture of incident reporting but acknowledged that sharing lessons learnt could be improved.

Between May 2017 and October 2017 826 incidents were recorded in the surgery division at North Manchester General Hospital with the largest category being patient accident/incident.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Duty of candour was observed in the investigation reports of the serious incidents we reviewed. Four of the five staff we spoke with regarding duty of candour were aware of the term and the principle behind the regulation.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 53 new pressure ulcers, 21 falls with harm and 10 new catheter urinary tract infections between July 2016 and July 2017 for Surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Pennine Acute Hospitals NHS Trust

![Graph showing prevalence rate of pressure ulcers](image)
October 2016 saw the highest number of pressure ulcers, falls and C.UTIs recorded during the period.
(Source: NHS Digital)

Safety thermometer information was included on ‘Open and Honest’ notice boards displayed at the entrance to each ward and department. Information included the number of days since an MRSA infection, Clostridium Difficile infection, pressure ulcer or fall had occurred in the area.

Is the service effective?

Evidence-based care and treatment

The service used National Institute for Health and Care Excellence (NICE) guidelines and guidance from authorities such as the Royal College of Surgeons to determine care and treatment. We observed Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines in theatres and ward staff could describe the use of evidence based guidance that underpinned care for example in preoperative fasting guidelines, use of post-operative analgesia, when assessing nutritional status or pressure ulcer care.

The hospital used Fall Safe Care Bundle assessments as part of the admission process and the ‘Sepsis Six’ care bundle to improve outcomes for patients with sepsis. Surgery and anaesthesia directorates across the trust contributed to the Advancing Quality-Sepsis audit. The surgical division also contributed to a number of national audits such as the Hip Fracture Audit and the National Emergency Laparotomy Audit.

Managers told us that introduction of National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) were well advanced and we observed examples of LocSSIPs in use within the surgical division.

The World Health Organisation (WHO) Surgical Safety Checklist Five Steps to Safer Surgery was used in theatre however we observed inconsistent implementation on several occasions.

The hospital had signed up to the End PJ Paralysis campaign which aimed to get patients out of bed and dressed during the day. Increased activity helps recovery and promotes independance leading to patients being discharged earlier.

Nutrition and hydration

Fasting guidelines were in place to ensure patients were not deprived of food or fluids for longer than necessary prior to surgery. A range of meal options were available for patients and those we
spoke with were positive about the food offered however, some patients intake had been limited due to their condition and possible surgery.

During admission patient’s nutritional status was assessed using the Malnutrition Universal Screening Tool. Any patient identified as malnourished or at risk of malnutrition was referred to the dietetic service. Referral was completed electronically and staff reported this resulted in a prompt response. We observed water jugs being changed during our inspection.

**Pain relief**

Staff told us how they assessed pain using verbal and non-verbal cues and with the involvement of parents and carers if appropriate. We observed a patient being asked to score their pain in an attempt to ensure the appropriate level of analgesia was administered. Patients told us that pain relieving medication was brought promptly when requested. The acute pain team were available to assist patients identified as requiring additional support following surgery such as patient controlled analgesia and a referral could be made to the chronic pain service if needed.

At our last inspection the pain management services were noted not to be fully compliant with the ‘Core Standards for Pain Management, Faculty of Pain Medicine’ when assessed by the trust. During this inspection pain management services remained non-compliant however plans were in place to address outstanding issues. This service was based at another trust location.

**Patient outcomes**

Patient outcomes were monitored in divisional mortality and morbidity meetings and clinical governance meetings.

At our last inspection staff had identified that outliers (patients situated away from the speciality they should have been admitted to) were not reviewed daily. There were four medical outliers on surgical ward I5 during our inspection. We observed medical staff attending to review these patients however staff across the surgical directorate told us this did not always occur daily.

**Relative risk of readmission**

**Trust level: Elective admissions**

Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology and Colorectal Surgery patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Trust Level: Non-elective admissions**
Between May 2016 and April 2017;

- All patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- General Surgery, Trauma & Orthopaedics and Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

North Manchester General Hospital: Elective Admissions

Between May 2016 and April 2017;

- All patients at North Manchester General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology, Trauma & Orthopaedics and Oral Surgery patients at North Manchester General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

We asked managers about the higher than expected readmission rates at North Manchester General Hospital. This was attributed in part to some patients requiring treatment prior to surgery and some complex surgery requiring multiple admissions although only involving one episode of care.
North Manchester General Hospital: Non-Elective Admissions

Between May 2016 and April 2017:

- All patients at North Manchester General Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General Surgery and Urology patients at North Manchester General Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at North Manchester General Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

Hip Fracture Audit

North Manchester General Hospital:

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7% which was within the expected range. The 2015 figure was 6.9%.

The proportion of patients having surgery on the day of or day after admission was 44.4% which was worse than the national standard of 85%. The 2015 figure was 58.6%.

The perioperative medical assessment rate was 98% which failed to meet the national standard of 100%. The 2015 figure was 81.4%.

The proportion of patients not developing pressure ulcers was 94.8%, which falls in the middle 50% of trusts. The 2015 figure was 96.4%.

The length of stay was 24.4 days which falls in the bottom 25% of trusts. The 2015 figure was 20.2 days.

(Source: CQC Insight - National Hip Fracture Database 2016)

An action plan following the 2016 Hip Fracture Audit indicated the movement of elective hip and knee surgery to a neighbouring hospital within the trust in the months prior to our inspection. This would increase the number of trauma patients having surgery within 36 hours.

Bowel Cancer Audit
In the 2016 Bowel Cancer Audit, 79.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 72.7%.

The risk-adjusted 90-day post-operative mortality rate was 7.8% which was worse than expected. The 2015 figure was 5%.

The risk-adjusted 2-year post-operative mortality rate was 24.9% which was within the expected range. The 2015 figure was 22%.

The risk-adjusted 30-day unplanned readmission rate was 9.9% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 58.2% which was worse than expected. The 2015 figure was 61.6%.

(Source: CQC Insight - National Bowel Cancer Audit)

National Vascular Registry

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.3% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2015 figure was 2.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 10 days, which was better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 1.6% which was within the expected range. The 2015 figure was 1.6%.

(Source: CQC Insight - National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.6%. This placed the trust within the top 25% of all trusts for this measure. The 2015 figure was 4.5%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9% which was similar to the national aggregate. The 2015 figure was 41.6%.

This metric is defined at strategic clinical network level; (the network can represent several cancer units and specialist centres) the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: CQC Insight - National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

North Manchester General Hospital:

In the 2016 National Emergency Laparotomy Audit (NELA), North Manchester General Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 95 cases.

The Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 60 cases.
The hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 39 cases.

The hospital achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 24 cases.

The risk-adjusted 30-day mortality for North Manchester General Hospital was within the expected range based on 117 cases.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

Between April 2016 and March 2017 performance on groin hernias, hip replacements and knee replacements was about the same as the England average.

For varicose veins, performance was about the same as the England average, aside from the Aberdeen Varicose Vein Questionnaire where performance was worse than the England average.

*(Source: NHS Digital)*

**Competent staff**

**Appraisal rates**

Between June 2016 and May 2017, 79% of staff working within the Surgery & Anaesthesia division at the trust had received an appraisal compared to a trust target of 90%.
The 79% appraisal rate applies to nursing and midwifery registered, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At North Manchester General Hospital 74% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff identified their learning needs through the trust’s appraisal process. All staff we spoke with reported receiving annual appraisals and described opportunities for development in their role. The compliance summary for the Division of Surgery at North Manchester General Hospital showed at the time of our inspection appraisal rates were 70% compared to a target of 90%. Induction processes were in place for new staff and preceptorship was in place for newly qualified staff. Junior medical staff reported they felt supported.

Medicines management competencies were in place to enable nursing staff to administer intravenous antibiotic therapy and critical care outreach training had been delivered to staff on ward I5.

Multidisciplinary working

Multi-disciplinary meetings were held daily. We observed a meeting on ward I5 involving physiotherapists, occupational therapists, nursing staff and a patient flow co-ordinator. This ensured plans were in place to deliver effective care to patient’s. Details shared included diagnosis and investigations an update on therapeutic intervention, plans for discharge and involvement of social care.

Records we reviewed indicated evidence of multi-disciplinary team work where appropriate.

Seven-day services

Emergency theatres operated between 08:00hours and 20:00hours and staff were available on call over night.

Physiotherapy services were available at weekends to care for patients assessed as a priority.

Access to information

Policies and procedures were kept on the trusts intranet and staff were familiar with how to access them. Letters to a patients general practitioner (GP) were sent following attendance for day surgery and district nursing services arranged as required. Information provided on referrals included allergies, prescribed medication, pre-existing conditions and details of the procedure completed.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Data for this metric was not provided.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Planned surgical procedures were discussed during outpatient clinic consultations however nursing staff, medical staff and managers told us consent for surgery was taken on the day of the procedure in the majority of cases. This does not comply with accepted best practice as the Royal College of Surgeons recommends ‘the patient has sufficient time and information to make an informed decision’. We observed consent being taken from a patient on arrival at the day surgery unit, the procedure, levels of discomfort, post-operative pain relief and discharge plan were discussed and following a clear explanation, the doctor was observed re-checking the patients understanding of the conversation.

Training on Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DOLS) was incorporated in mandatory safeguarding training. Staff could describe the process of assessing capacity however, despite the trusts MCA policy flow chart stating ‘all adults should be presumed to have capacity unless the opposite has been demonstrated’, mental capacity assessments were completed on all patients on admission to the Surgical Triage Unit. Following the inspection, the trust told us that this was part of a planned pilot to improve compliance with the assessment of patients’ capacity within surgery. The results will inform whether a formal change is made to the Trust policy.

Staff described how they would deal with patients attending the day surgery unit without capacity including escalation to medical staff, involvement of family members and arrangement of best interests meetings as required.

We reviewed one record of a patient subject to a DOLS order. The DOLS order had expired and the patient had subsequently been seen by a social worker however, there was no entry in the patients records to indicate what further action if any, had been taken.

We reviewed four records of patients who were identified as requiring assessment and completion of ‘do not attempt cardiopulmonary resuscitation’ (DNACPR). All records had evidence of a mental capacity act assessment however only one had a review of the DNACPR.

**Is the service caring?**

**Compassionate care**

Since our last inspection North Manchester General Hospital had introduced the Nursing Assessment and Accreditation Score (NAAS) on the wards. This is a performance assessment framework that measures the quality of nursing care delivered by individuals and teams. It is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. Staff we spoke with were very positive about the impact the introduction of the scheme had on the care and performance delivered in their clinical area.

During our inspection patients we spoke to were positive regarding the care they had received describing the staff as ‘nice’ and stating ‘they couldn’t fault it’.

We observed staff interacting with patients both in person and by telephone, treating them with kindness and respect. One interaction involved a member of the catering staff discussing lunch options with an elderly lady. The staff member was observed getting down to eye level, speaking clearly but gently to the lady and allowing her to take her time with the choices offered.

We also observed positive interactions between staff who were willing to assist each other with tasks despite high levels of activity in the department.

The hospital had signed up to the End PJ Paralysis campaign to support patients to be mobile and independent post-operatively. However, following observation of a nurse handover in a bay on ward I5 we raised concerns regarding the lack of privacy and confidentiality with the ward manager as patient details were discussed in an open environment.
Friends and Family test performance

Between August 2016 and July 2017 the Friends and Family Test response rate for Surgery at The Pennine Acute Hospitals NHS Trust was 26% which was slightly worse than the England average of 29%

A breakdown of response rate by site can be viewed below.

A breakdown of percentage recommended by site and ward is shown below:

(Source: NHS England Friends and Family Test)

Managers in areas with a high proportion of elderly or confused patients described difficulty in obtaining patient uptake for the Friends and Family Test.
Emotional support

Involvement with the Pioneer staff engagement project had enabled staff on ward F5 to decorate the relatives room to make it a calm, welcoming, quiet space for relatives who wished to use it. Carers of patients with dementia were encouraged to stay throughout admission to the day surgery unit and accompany their relative to theatre to provide emotional support.

We observed information given to patients verbally and in written format regarding their condition and treatment.

Diabetes nurse specialists were available for patients to talk to about their condition.

Understanding and involvement of patients and those close to them

Patients we spoke with stated they felt consulted regarding their treatment and had been kept informed of their plan of care.

Staff in the day surgery unit described how patients who attend with dementia or additional needs were accommodated. Examples of care provided included taking one patient straight to theatre and subsequently discharging from there to reduce waiting and the need to move around the department, a visit to the department by a parent in advance of a patients admission to review the environment and discuss any individual needs, and receiving a patients Traffic Light document by email in advance of attendance to ensure care was appropriately tailored to specific needs.

Is the service responsive?

Service delivery to meet the needs of local people

The waiting areas in the day surgery unit lacked decoration and a patient and relative described the main waiting environment as ‘depressing’, stating the chairs were hard and uncomfortable.

Ward I5 had developed dementia boards and boxes that provided tactile and sensory activities for patients.

Staff described how they had sought support and advice from the Learning Disabilities Lead Nurse when caring for patients with Autism or complex needs.

Average length of stay

Trust level: Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all elective patients at the trust was 2.6 days, which is lower than the England average of 3.2 days.
- Average length of stay for Trauma & Orthopaedics, Urology and General Surgery elective patients at the trust is lower than the England average.
Trust Level: Non-Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at the trust was 5.1 days, which is the same as the England average.
- Average length of stay for General Surgery non-elective patients at the trust was 4.0 days, which is the same as the England average.
- Average length of stay for Trauma & Orthopaedics and Urology non-elective patients was similar to the England average.

North Manchester General Hospital: Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all elective patients at North Manchester General Hospital was 2.5 days, which is lower than the England average of 3.2 days.
- Average length of stay for Urology and General Surgery elective patients is lower than the England average.
- Average length of stay for Trauma & Orthopaedic elective patients is similar to the England average.

North Manchester General Hospital: Non-Elective Average Length of Stay
Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at North Manchester General Hospital was 5.0 days, which is similar to the England average of 5.1 days.
- Average length of stay for General Surgery and Urology non-elective patients is the same as the England averages.
- Average length of stay for Trauma & Orthopaedics non-elective patients is higher than the England average.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

Staff described how people in vulnerable circumstances were accommodated in the day surgery unit. Visits could be arranged prior to admission to allow patients to become familiar with the environment and coloured patient identification bands were in use to let staff know at a glance if a patient had additional needs or was diagnosed with dementia.

Carers of patients with dementia were encouraged to stay throughout admission to the day surgery unit and accompany the patient to theatre. Open visiting on wards allowed family to visit and be present at mealtimes if they wished.

Access to interpreting services could be arranged for those patients whose first language was not English. Face to face translators could be booked in advance at preoperative assessment clinic and interpreters could accompany patients to theatre or complete ward visits to support therapy assessments however, we did not see this system in use as we did not observe any patients requiring translation services during our inspection.

There was equipment for bariatric patients and an equipment co-ordinator was available to source additional items such as bariatric chairs or commodes.

There was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. They were only in English but could be ordered in other languages or alternative formats if required.

The Rapid Assessment, Intervention and Discharge service provided services to patients not known to mental health services but who required assessment. We observed discussion of referrals as part of the multi-disciplinary discussion on ward I5.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

Between August 2016 and July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for Surgery has been consistently better than the England average.

As of July 2017 73% of patients were treated within 18 weeks compared to the England average of 70%.
Referral to treatment (percentage within 18 weeks) – by specialty
A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, three of the specialties were above the England average and three of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>96.1%</td>
<td>74.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>85.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>81.9%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>74.8%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.9%</td>
<td>77.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>65.2%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>62.4%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Between Q2 and Q4 15/16, the trust slightly improved performance so that no patients had to wait longer than 28 days for treatment after their operation was cancelled. This was despite the number of cancelled operations rising during the period from 191 to 308.

However in Q1 16/17 performance declined so that although the number of cancelled operations had reduced to 215, 8% of those patients were not treated within 28 days of their cancellation.

The declining trend has continued until Q1 17/18 and 8% of the 326 patients whose operation was cancelled, did not receive treatment within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days
- The Pennine Acute Hospitals NHS Trust
Over the two years, the percentage of cancelled operations at the trust showed an overall trend of decline. Q1 and Q2 16/17 saw some improvements, although has been deteriorating since. Throughout the period the percentage of cancelled operations was generally higher than the England average.

Cancelled operations as a percentage of elective admissions includes only short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - The Pennine Acute Hospitals NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions over time.](image)

(Source: NHS England)

All patients attending for elective surgery were admitted through the day surgery unit. Attendance times were staggered in an attempt to reduce patients waiting times in the department. The concept of ‘the golden patient’ had also been introduced. This process prioritised a patient for the first surgical procedure of the day to prevent any delay to the start of the theatre list.

Data from the trust showed the number of operations cancelled on the day between August 2017 and October 2017 at North Manchester General Hospital was 274. Reasons for cancellation included 44 cases where beds were not available, 34 cases where the surgical list over ran and 26 cases which were cancelled for medical reasons.

We spoke with three patients who had transferred to North Manchester General Hospital by ambulance, all were positive regarding their experience.

**Learning from complaints and concerns**

**Summary of complaints**

Between June 2016 and May 2017 there were 257 complaints about Surgery (31.6% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 65 complaints still open and yet to be completed.

There were 109 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 42%.

- North Manchester General Hospital: There were 113 complaints (44.0%)

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Between 1 July 2017 and 31 October 2017 a further 48 complaints were received by the division of surgery at North Manchester General Hospital. Lessons learnt from complaints were shared in safety huddles however the service did not always investigate complaints in a timely manner as
per their policy. Minutes from the Division of Surgery Governance and Quality Board in September 2017 stated there was a continued problem with long standing complaints.

Is the service well-led?

Leadership

Since our last inspection there was a new director and divisional management structure with the formation of Care Organisations. The divisional leadership team consisted of a divisional clinical director, divisional managing director and a divisional director of nursing. Some personnel had only recently come into post prior to our inspection therefore the team was still embedding.

Staff reported that management at all levels were visible and spoke positively regarding new senior nurse appointments. Staff on ward F5 who had seen a significant improvement in the Nursing Assessment and Accreditation Score (NAAS) for the ward and described how senior managers had come to the ward to acknowledge their achievement. NAAS is a performance assessment framework designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed.

Wards and departments were led by band 7 managers or team leaders supported by band 6 staff.

Safety huddles were conducted at the beginning of each shift which allowed information to be shared with staff.

Staff received a weekly email which contained updates on relevant trust information.

Vision and Strategy

The trust’s values were to be quality–driven, responsible and compassionate and the ‘Open and Honest’ noticeboards situated at the entrance to each ward and department reflected the values with the information displayed.

Staff we spoke with were aware of the values and how they applied them in practice.

The strategy for the surgical division included improving care and services through integration and collaboration and supporting staff to deliver high performance and improvement. Staff in theatres were aware of the impact of proposed changes and were generally positive about them.

Culture

Staff and managers told us morale was variable dependant on workload and acuity of patients however, all described a good team working culture.

Results of the 2016 NHS Staff Survey from across the trust showed 48% of staff would recommend the organisation as a place to work compared to a national average of 62% and 52% stated if a friend or relative needed treatment, they would be happy with the standard of care provided by this organisation compared to a national average of 70%. The trust also ranked in the lowest 20% of all acute trusts for the percentage of staff believing the organisation provides equal opportunities for career progression or promotion.

Governance
Monthly divisional clinical governance meetings took place and were attended by senior staff including medical and nursing staff and clinical audit and governance leads. Discussions took place regarding issues such as complaints, risks, serious incidents and lessons learnt and a monthly divisional lessons learnt newsletter was circulated to staff. An example of an identified change in practice as a result of a serious incident included the need to formalise the continued review of patients who were deemed medically fit for discharge but who faced social care delays within trauma and orthopaedics.

Safety huddles took place at the beginning of each shift and included safeguarding issues and themes of the week.

Management of risk, issues and performance

Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments.

A dashboard was used to monitor quality and performance and included the number of non-clinical cancelled operations, theatre utilisation, the number of operations cancelled and rebooked within 28 days and the average theatre cases per session. Finance and activity relating to clinical income and expenditure was monitored in the Integrated Performance report and a clinical and internal audit programme was in place.

Information Management

Paper patient records were securely stored in locked trolleys in all areas we visited.

The trust collected and analysed information to support all of its activities. However we reviewed the performance monitoring dashboard for surgery which included data regarding implementation of the World Health Organisation Surgical Safety Checklist Five Steps to Safer Surgery. Despite data from the trust indicating that between April 2016 and June 2017 compliance with the WHO Checklist ranged from 99% to 100%, on several occasions during our inspection it was noted that not all elements of the checklist were observed.

Engagement

The Staff Engagement Pioneers Programme introduced as part of the action plan following the 2016 NHS Staff Survey was described very positively by staff who demonstrated tangible benefits to their environment such as approval for a water cooler on ward F5 and future plans to raise funds for equipment.

Staff also spoke very positively about their engagement with the NAAS scheme and how proud they felt of improvements which were subsequently reflected in their ward scores.

Staff received a weekly email which contained updates on relevant trust information.

North Manchester General Hospital surgical division participated in the NHS Friends and Family test (FFT) and information about how patients and those close to them could provide feedback was displayed in ward areas.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning both following incidents when investigations were completed and lessons learnt were shared with staff and through mortality and morbidity reviews following a patients death.

Medical staff described how the purchase of a 3D printer had significantly reduced the cost of custom made prosthesis for surgery.
The oral maxillofacial service had developed an ‘add on’ to the WHO checklist for complex surgical cases that were time consuming and may involve team changes in theatre during the procedure. These included any additional preparation required, as well as the time additional staff would be needed in theatre and any ‘extras’ such as a quiet environment for the patient during anaesthesia.

**Maternity**

### Facts and data about this service

Pennine Acute Trust has 133 Maternity beds, split across two sites, North Manchester General Hospital and The Royal Oldham. Both hospitals provide obstetric services with co-located birth centres. 

At the time of inspection there were 58 beds, 28 postnatal and 12 labour rooms on the consultant unit, including a pool room, a high dependency unit room and a bereavement room’.

*(Source: Trust Routine Provider Information Return (RPIR) – Acute sites, CQC Insight)*

Between April 2016 and March 2017, there were 8,997 deliveries at the trust. A comparison between the number of births at the trust and the national totals during this time period is shown below.

* (SOURCE: HES - Deliveries (01/04/2016 - 31/03/2017)*

A profile of all deliveries between April 2016 and March 2017 is shown below.
The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
Mandatory training

The service provided mandatory and obstetric specific training in key skills to all staff and most staff had completed it.

The mandatory training information provided during the inspection was for staff working in maternity services and did not include those in the children’s service. This showed core training compliance was at 93% which was above the trust’s target and essential job related training was at 83%. This included basic life support for adults at 95%.

Since the last inspection a team of three midwives had been appointed as practice educators. There were two practice educator midwives at North Manchester General Hospital and one at the Royal Oldham Hospital. Their main role was to support staff to complete their mandatory training, develop specific training packages, design competence assessment tools and audit practice to identify learning needs.

One of the practice education midwives was a trainer for basic life support. This had been introduced as part of the Practical Obstetric Multi-Professional Training training day. This training was compulsory for all midwives and medical staff in the obstetric department. Compliance with this training was 92% which was above the trust’s target of 90%.

An external neonatal life support training course was being reviewed by the practice education midwives. In the interim of this being available an in-house course had been developed and delivered to staff. 92% of staff had completed this training.

Training in the recognition, assessment and management of sepsis had been included as mandatory for all midwifery staff. 44% of the staff who required this training had completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services as well as those working in maternity services)

During the inspection the up to date training compliance for maternity services was provided. This did not separate medical staff from midwifery staff. The information provided is included in the text of this report.
Medical and dental staff in the Women’s and Children’s division met the 90% target for mandatory training compliance for three modules only.

Basic life support training had the lowest compliance levels with only 60% of eligible medical and dental staff having been trained.

Nursing and midwifery staff in the Women’s and Children’s division met the 90% target for mandatory training compliance in five modules. Both waste management and infection prevention (non patients) achieved 100% compliance, however the requirement for eligible staff members for these modules was very low with only one and two members respectively eligible for training in these areas.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However midwives did not receive safeguarding supervision.

Information provided during the inspection showed that 92% of staff in maternity services had completed safeguarding children level three training. This was above the trust’s target of 90%. The compliance in safeguarding adults training level three was 91%.

There was a specialist midwife with the lead for safeguarding practice in the maternity services. They were part of the trust’s safeguarding team. Staff spoke about how this person provided advice and support with any safeguarding concerns they raised.

There was a lack of documentation regarding assessment of risk of abuse of both women and babies in the files we saw. Special circumstances forms were used, but the record that the relevant questions were asked to detect any concerns at each interaction with a midwife were not clearly documented. This was discussed with the trust safeguarding lead and would be included in the trustwide review of safeguarding processes.

The new system of practice reviews, where cases were discussed with staff of various grades, included those patients where safeguarding concerns had been raised. Any learning from issues arising through these discussions was shared by the safeguarding specialist midwife with those involved.

There was no system of safeguarding supervision in place for midwives. One of the underlying principles of the Intercollegiate Document 2010 is that those working with children and young people or parents should include clinical governance and supervision as part of their learning. There were plans to implement this however no timescale was provided by the trust.

The community midwives used the local children’s centres as their base. This meant there was opportunity to discuss any concerns they might have about a mother or babies.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s and Children’s Division is shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s and Children’s Division, this therefore includes staff that work in other services as well as those working in maternity services)
The 90% target was not met for any of the safeguarding modules by medical and dental staff in the Women’s and Children’s division at the trust. The target for level two children’s training compliance was almost achieved with 89.5% compliance which equated to 145 of the 162 eligible staff members completing the training.

Nursing and midwifery staff in the Women’s and Children’s division exceeded the 90% completion target for both level two adults and children safeguarding modules. However the target for level three safeguarding was not met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene
The service controlled infection risk well.

All areas of the maternity unit we visited were visibly clean and tidy.

We saw staff washing their hands and using the hand gel available between interactions with women. Staff reminded visitors to use the hand gel which was available in all areas of the service. Personal protective equipment was provided and we saw staff using this appropriately.

Hand hygiene and personal protective equipment audit information was displayed on the boards at the entrance to the various units. Audits for the previous four months showed of those areas of maternity services where hand hygiene and use of personal protective equipment was assessed had scored 100%.

Information provided by the trust showed there had been two cases of women being positive when screened for Methicillin-resistant Staphylococcus aureus and one episode of C.difficile between October 2016 and August 2017. Appropriate action was taken. An investigation into the case of C.difficile was completed with input from the infection prevention and control lead.

Managers had carried out an investigation with the infection prevention and control manager due to a rise in sepsis cases in maternity services. Information provided by the trust showed this had risen to 4% of births in June 2017 from 2% in May 2017. They had found the classification of sepsis had been used when this was not the actual diagnosis. A staff education programme had taken place. However the rate remained at over 2% in September 2017.

There was a system in place to clean the birthing pools. The temperature of the water was checked; however records showed this was not recorded clearly or consistently on patient records. This had been raised at the last inspection and remained unchanged.

Environment and equipment

The service had suitable premises and equipment however not all equipment was well looked after. Some of the equipment used in an emergency had not been checked at a frequency that was in line with the trust’s policy. This included resuscitation equipment for women and babies.

On the labour ward records we reviewed showed for week commencing 2 October 2017 three equipment checks had not been recorded on one day and one equipment check on two days. Week commencing 18 September 2017 none had been checked on the Thursday and three were missed on the Friday. This included resuscitaires for babies. There were also some gaps in the records on the antenatal ward and the birth centre; however records on the postnatal ward showed these checks had been completed.

The records for the checking of the emergency trolley in the antenatal ward did not match with the frequency of the trust’s policy. Staff reported it should be a weekly check however there was no record of a check between 17 September 2017 and 1 October 2017. Following this it had been checked 11 times up to the 17 October 2017.

We saw fridges were within range and temperature checks had been completed.

Staff reported they had enough equipment to meet the demands of the service. This included monitoring equipment such as cardiotography.

An electronic fetal monitoring system had been introduced the week of the inspection. Staff had received training to use this equipment and specific midwives had been identified to provide ongoing support during its implementation.

The equipment in theatres, such as the anaesthetic equipment, had been checked. We saw staff carrying out routine equipment checks prior to surgery taking place.

Assessing and responding to patient risk
The Maternity Early Warning Scores assessments to detect deterioration in a woman’s condition were not completed in the prescribed timescales. Women were not having their condition assessed to ensure deterioration in their condition was identified.

We reviewed fourteen Maternal Early Warning Score records. On the antenatal ward all records had been fully completed and the patient’s condition was escalated to medical staff in line with the policy. On the labour ward one warning score was reviewed and one observation parameter was not recorded out of a total of eight observations documented. On the postnatal ward five records were checked. For two patients their observations had not been reassessed in the timescales outlined in the escalation policy. This included one patient whose records at 0900 indicated they should have been reviewed within four hours. However, the next recorded re-assessment was at 21.05 which was not within the trust’s policy.

An audit of 86 maternity early warning score records was completed in the maternity department in October 2017. This showed improvements had been made from the previous audit in four of the measures which were reported on both times. Of the nine measures in the audit three met the trust’s standard of 100%. Of the remaining measures the scores were between 70% and 97%. There was a meeting arranged in November 2017 to develop an action plan. Quarterly audits would continue.

Staff completed risk assessments for venous thrombo-embolism.

The neonatal early warning scores’ records were not colour co-ordinated to indicate risk. This meant if the assessment indicated a risk of deterioration it was not easily identified. Changes had been made to this documentation at The Royal Oldham hospital and we were told it was due to be introduced at this site.

Information provided during the inspection showed that 54% of staff had completed an on-line training course about the management of deteriorating patients. This included acute illness management for patients who were in the high dependency unit. We saw only staff who had completed this training were allocated to work in that area. The practice education midwives were working with the critical care educators to develop the maternal acute illness management training.

We observed effective joint working between obstetric staff and critical care staff to provide care to acutely unwell women on the labour ward. Frequent medical reviews took place and support was given to midwives by the critical care outreach team.

We observed the World Health Organisation surgical safety checklist to be implemented correctly in theatre. A prospective observational audit of the surgical safety checklist had been carried out for 5 days in March 2017. This showed 100% compliance with nine of the eleven steps of the surgical safety checklist. The two areas below full compliance were the team brief at 90% and the silence during time out at 80%. There was an action to share the results and re-iterate the checklist’s use.

There was an emergency call bell on the maternity assessment unit and triage area which went through to the labour ward. This meant appropriate staff could be quickly called in an emergency.

A new risk assessment had been developed which was used at the booking appointment. This included risk factors which would lead to consideration of consultant led care and not midwifery led care. This was in the pilot phase and would be reviewed in January 2018.

In the patients’ records we reviewed on the labour ward an assessment of the woman’s condition was included in the documentation when the care was handed over to another midwife.

**Midwifery staffing**
The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Since the last inspection staffing numbers had increased with the employment of 84 midwives across the trust in the past 12 months. Midwives, health care assistants and managers told us that staffing had improved significantly although there were still some vacancies. Information provided by the trust showed nine incidents due to staff shortaged had been reported between August and October 2017. We were told by staff that this was a reduced number on the previous year.

The trust reported the following planned and actual staffing figures for nursing and midwifery registered staff working in maternity and obstetrics and gynaecology for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 16</td>
<td>337.71</td>
<td>346.87</td>
<td>54.03</td>
<td>59.35</td>
</tr>
<tr>
<td>January 17</td>
<td>333.31</td>
<td>346.87</td>
<td>55.67</td>
<td>60.35</td>
</tr>
<tr>
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<td>March 17</td>
<td>329.45</td>
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<td>55.73</td>
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</tr>
<tr>
<td>April 17</td>
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<td>346.87</td>
<td>54.85</td>
<td>63.70</td>
</tr>
<tr>
<td>May 17</td>
<td>329.15</td>
<td>346.87</td>
<td>54.85</td>
<td>65.21</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

A system had been introduced to ensure the right number and skill mix of staff was in place in each area of the maternity services. This consisted of a senior manager visiting each unit every four hours to assess the activity, staffing numbers, skill mix and anticipated activity. This meant one person had oversight of the risks throughout the whole maternity service at any one time. This person was the point of contact for any changes in activity such as emergency admissions. We saw this worked well in practice and staff told us it had reduced the risks to women of not having enough staff in high risk areas.

Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 5.0% for nursing and midwifery staff in maternity and 8.5% in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

On the labour ward there was a vacancy rate of 11 whole time equivalent midwives. On the postnatal ward it was 1.8 whole time equivalent. Recruitment to these posts was continuing.

Turnover rates

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.3% for nursing and midwifery staff in maternity and 1.4% in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Between June 2016 and May 2017 the trust reported an average sickness rate of 5.9% for nursing and midwifery staff in maternity and 4.9% in obstetrics and gynaecology, both being above the overall trust target of 4.6% for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

We saw there was use of agency staff in all areas of the maternity services. However staff reported this had reduced significantly since the last inspection and where possible the same agency staff were used to provide consistency in each area. Managers and other staff told us the number of agency staff used did not impact adversely on the care provided to women as they always worked alongside the trust’s own staff.

Midwife to birth ratio

We were told by senior managers the birth to midwife ratio was 1:24. This met The Safer Childbirth Minimum Standards for the Organisation of Delivery of Care in Labour (October 2007) recommendations of 1:28.

The service used a tool for calculating staffing levels. This had been reviewed since the last inspection and was kept under review to ensure it was accurate.

Of the 23 beds available on the antenatal ward at the time of the inspection 18 were in use and the remaining bay of five was closed. The staffing establishment on this ward had been changed and staff told us they felt the numbers of staff on duty was not always sufficient for the activity of the ward. This was due to a current lack of administration staff resulting in midwives undertaking these duties and the health care assistants being moved to other wards. However, we did not see that this was impacting on patient care.

Staff were reporting incidents when there were concerns due to low staffing numbers or high activity. We were told these incidents had decreased since the last inspection and were mainly that staff did not have their breaks. The skill mix on the labour ward was assessed each day and we saw there were sufficient experienced midwives to support those less experienced. There were two health care support workers on each shift and there were plans to increase this on the days with elective caesarean sections.

On the postnatal ward there was additional staffing to assist women with their new-born babies. These included a band four maternity care assistant, two band 4 nursery nurses and a band three discharge co-ordinator.

The documented staff rota on the wards was not always an accurate record of the actual staff who were working on the ward at any one time. When staff were moved at times of high activity to support busy areas this was not reflected on the rota. The electronic rota could not be updated with this information and was therefore not always correct. Some managers documented the times staff moved on the “rounding” record; however others did not. We saw the number of midwives on the ward was one less than recorded on the rota due to one having moved to an area of higher activity.

Medical staffing

The trust reported the following planned and actual staffing figures for medical staff working in obstetrics and gynaecology for the period December 2016 to May 2017.

Under the service of maternity – the trust has no records for medical staff figures; they all fall under obstetrics and gynaecology.

<table>
<thead>
<tr>
<th>Month</th>
<th>Obstetrics &amp; Gynaecology</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>WTE in post</td>
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20171019 900885 Post-inspection Evidence appendix template v2.0  Page 122
Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of -3.8% indicating an over establishment for medical staff in obstetrics and gynaecology.

- North Manchester General Hospital has had a number of medical staff vacancies month on month during the period, leading to an average vacancy rate of 6%.

(Source: Routine Provider Information Request (RPIR) P16 Vacancies)

During the inspection we were told five new consultants had been appointed. Four of these were due to start in November 2017 and one in January 2018. This would leave a vacancy rate of one and half posts.

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 1.3% for medical staff in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 3.1% for medical staff in obstetrics and gynaecology which is better than the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital – average of 2.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

The reliance on locum staff was one of the risks discussed by senior medical personnel. They were using locums to cover long term sickness in two posts. However recent recruitment would reduce the overall use of locum staff by January 2018.

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average, whilst the proportion of junior (foundation year
1-2) staff was slightly higher.

**Staffing skill mix for the 81.5 whole time equivalent staff working in Maternity Services at The Pennine Acute Hospitals NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

**Consultant cover on labour ward**

There was resident consultant cover on the labour ward Monday to Friday 24 hours a day. On Saturday and Sunday an experienced middle grade doctor was present on the ward. The on call consultant completed a ward round in the morning and would remain in the hospital if the activity meant this was required. They were available for emergencies. On Saturday and Sunday nights there was a resident consultant available. We were told the rota would be reviewed once the newly recruited consultants were in post.

There was a consultant anaesthetist on the labour ward daily from 8am to 5pm. Outside of these hours a middle grade doctor with appropriate experience was on the ward. They had support from the on call consultant anaesthetist.

Doctors who had recently started in this hospital reported that they got quick support from consultants should this be required. A consultant obstetrician was involved in all emergency caesarean sections.

Staff reported sufficient medical cover on the other maternity wards and departments including out of hours emergency cover. Should the resident doctor be unable to attend and medical care was thought to be urgent they would escalate this to the on call doctors.

Senior medical personnel told us they wanted to develop medical lead roles including labour ward and guideline leads.

**Records**

Appropriate records of women’s care and treatment were not kept in a way in which they could be shared with other health professionals. Following community midwife visits, including booking, there were delays in recording women’s information onto the electronic system.
The records for intravenous fluid administration had not been fully completed on all wards. We reviewed seven episodes of fluid administration on the postnatal ward and none were accurately completed. This included no start and finish times and no signatures. However those on the antenatal ward we reviewed were fully completed.

Other women’s records we reviewed on the postnatal and antenatal ward and those on the labour ward had been accurately completed.

On the antenatal ward there was no lockable trolley and so women’s records were kept in the unused patient bay on the ward and the door was locked.

The antenatal assessment record was completed whenever a woman called into the triage area. This information was passed by telephone to the community midwives when required.

Medicines

Medicines were appropriately prescribed, administered, recorded and stored within the service. We reviewed records for the controlled drugs held on the postnatal ward. These were completed with a daily and weekly check recorded.

Staff on the wards told us there could be delays to discharge women if the medicines to prevent a blood clot had not been prescribed by the doctor. This was felt to be a training issue about the assessment of risk and when these should be prescribed. Multidisciplinary training was planned.

There were 14 staff trained to administer intravenous antibiotics on the postnatal ward. We were told this meant there were no delays in the administration of these medicines.

Incidents

The service managed patient safety incidents well.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents in Maternity which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 2 maternity/obstetric incident meeting the criteria: mother and baby (this include foetus, neonate and infant)
- 2 maternity/obstetric incidents meeting the criteria: baby only (this include foetus, neonate and infant)
- 1 treatment delay meeting the criteria

(Source: Strategic Executive Information System (STEIS))
The system for the management of incidents had improved since the last inspection. There was a clear procedure for the reporting, allocation, investigation, and sharing of learning. This included weekly meetings to discuss all incidents in maternity services, including progress on investigations. There was no backlog of incidents waiting for investigation which was a much improved situation than at the last inspection.

We were given examples of where changes to practice had occurred following serious incidents. This included additional training for staff by the practice education midwives and additions to documentation. However, some staff we spoke with in the triage unit could not tell us of any changes in practice following a serious incident despite an action plan indicating the changes had been completed.

The new system of a weekly meeting to review all incidents meant any themes were recognised. We were given an example of a change to documentation when a theme of retained pessaries was identified. The outcomes of incidents was shared with staff through the safety huddles and displayed on ward boards.

Safety thermometer

The service did not use safety monitoring results well.

Information for the maternity safety thermometer was collected on the wards and departments. However, this had not been submitted to the NHS safety thermometer database since October 2016. This meant themes and trends could not be identified. We were told this information was collated, however an administration change had resulted in it not being submitted. This was not displayed in all relevant areas of the maternity units.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Guidelines were available online. Staff knew how to access these and those we reviewed had been updated and referenced the latest relevant national guidance.

A review following an incident identified that a clinical pathway for women who presented in maternity services, irrespective of where they initially presented and whether they were expected, should have been developed. Staff we spoke with were unaware of this and managers told us it had not yet been done despite the incident having occurred in December 2016. Midwives we spoke with in the triage areas gave conflicting information about how they would manage a medically unwell woman who presented unexpectedly. The other recommendations from the incident had been implemented.

Procedures for the management of emergencies were present in all the rooms on the labour ward. This included the management of post partum haemorrhages and shoulder dystocia.

Staff handovers we observed included the social, emotional and psychological needs of women and their partners. How to meet any specific or complex needs was discussed and staff were appropriately allocated, for example those with previous similar experience.

Sepsis screening was part of the maternity early warning score assessment when the observations indicated this was required. We saw this screening had taken place when women’s observations indicated it was required.
Nutrition and hydration

Women were supported to feed their babies whichever method they chose. Specialist support was available if they were experiencing any difficulties or had concerns.

There were facilities for women and partners to serve themselves to some meals whilst others were delivered to them. Where possible, independence was encouraged. We saw that special diets were catered for cultural or allergy purposes.

It was recorded in women’s records on the postnatal ward if there were any infant feeding problems. The actions taken and advice given were recorded.

There were two lactation consultant midwives at the trust and one full time and two part time infant feeding supporters. They supported parents to feed their babies, giving advice and one to one care.

Women spoke highly of the support offered with feeding their babies and said they were given a choice of how to feed them. The trust was Unicef Baby Friendly Accredited. The Unicef Baby Friendly Initiative supports breastfeeding.

Pain relief

Women reported they received their pain relief when they needed it and had not had to wait.

An anaesthetist was available 24 hours per day to ensure epidural analgesia could be administered in a timely manner.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

National Neonatal Audit Programme

In the 2016 National Neonatal Audit the trust’s performance was as follows:

North Manchester General Hospital:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour after birth?

There were 24 babies born at less than 32 weeks included in this audit measure for the unit. 96% of these babies had their temperature measured within an hour of birth; this was equal to the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 92 eligible mothers identified for inclusion in this audit measure for the unit. 80% of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

Between January and December 2016 the total number of caesarean sections and the standardised caesarean section rates for both elective and emergency sections were all similar to expected.
In relation to other modes of delivery between January and December 2016 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Pennine Acute Hospitals NHS Trust (The)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>2,453</td>
<td>27.0%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>864</td>
<td>9.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>5,753</td>
<td>63.4%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>9,080</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and venous (vacuum) deliveries
³Includes breech and normal (non assisted) deliveries

The trust had a slightly higher rate of non-interventional deliveries than the England average.
(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of 24 August 2017 the trust has no recorded Maternity outliers.
(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Prior to the inspection the trust was confirmed as a maternity outlier for emergency caesarean sections. We use the term 'outlier' to describe a service that lies outside the expected range of performance. Information provided by the trust showed the rate of emergency caesarean sections was around 20% of total births for August and September 2017. This rate had been above the England average since October 2016.

Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2016 audit and their stabilised and adjusted extended perinatal mortality rate (per 1,000 births) was 5.90 (5.02 to 7.39). The comparator group was 6.44.
(Source: MBRRACE UK)

Patient outcomes data was presented on the dashboards. These were displayed in most areas of the maternity services. Staff we spoke with, including senior managers, said there were information technology issues which were preventing them from accessing the dashboards online. This had been reported.

Information from the dashboards was discussed as part of the governance meetings; however we saw an example of where the information showed a performance worse than the England average and no actions to improve were in place.

New guidelines for the management of postpartum haemorrhage had been introduced and simulation exercises included in the Practical Obstetric Multiprofessional Training.
implementation of this had been audited and we were told improvements made as a result which included changes in the portering arrangements for blood products.

A report about the activity in the birth centre was completed for quarter two 2017/18. This documented the outcomes for women who had attended this area including the mode of delivery. A review of the reasons for transfer to the labour ward and the postnatal ward was included.

**Competent staff**

The majority of staff were competent for their roles.

At the last inspection concerns were raised about midwives who assisted in obstetric theatres for caesarean sections without their training being up to date or their competence assessed. At this inspection qualified theatre staff were used for elective caesarean sections. However, midwives still provided assistance in theatre with some emergencies. This had occurred six times between 19 July and 19 October 2017. All staff who are able to scrub had undergone a competency assessment and the evidence folder was kept on the labour ward. A theatre paper was submitted requesting that main theatres support the day to day running of maternity theatres. This was currently going through the governance of the organisation for approval.

Managers told us staff competence to work in the various areas of the maternity service was discussed as part of the appraisal process. This meant should staff be asked to move at times of high activity the experience and skills of staff to work in that area had been discussed.

**Appraisal rates**

Between June 2016 and May 2017, 88% of staff working within the obstetrics specialty within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 90%.

The 88% appraisal rate applies to nursing and midwifery registered, administrative and clerical and additional clinical services staff.

The trust confirmed that 100% of medical and dental staff had received an appraisal.

Appraisal rates across all staff groups split by hospital site is shown below:

At North Manchester General Hospital 88% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Simulation training for obstetric emergencies such as major haemorrhage and sepsis was provided.

We saw that midwives who were new to the trust worked in a supernumerary capacity alongside an experienced midwife until they were competent to work alone.

Systems were in place to support newly qualified midwives and those new to the trust. This included a buddy system and training and development opportunities. They told us they felt supported and could ask for assistance or advice whenever it was needed.

Since the recognised system of the supervision of midwives had ceased no alternative system for supervision had been developed. We were told discussions were taking place to agree what actions to implement.

Information provided by the trust showed 97% of medical and midwifery staff had completed training and competence assessment in fetal heart rate monitoring. 100% of birth centre staff and 85% of community midwives had also completed this.

Training to use the newly introduced electronic fetal monitoring equipment was in place. 59% of medical staff and 71% of midwives had completed this training. Four midwives from the triage
The unit had completed an electrocardiogram training course.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients.

We observed midwifery and medical staff discuss patients’ care and treatment professionally, requesting each other’s opinion and agreeing plans for care.

There was a handover of patients’ care between shifts which included midwives, obstetric doctors and anaesthetists as appropriate to the activity of the day. Relevant patient information was shared including risks and any additional emotional or social complexities.

The service participated in work stream oversight meetings, chaired by the Director of Nursing and with representation from North Manchester General Hospital and a neighbouring Trust. This was to monitor the effectiveness and risks of the work streams. The meetings were due to cease as part of a planned withdrawal of support from the neighbouring Trust, once it was clear that the service was able to incorporate the work of the various work streams into business as usual by the Trust.

Multidisciplinary antenatal clinics took place. These included diabetes and perinatal mental health.

**Seven-day services**

Sonography services were available Monday to Friday 8am to 5.30pm. There were plans to extend this to evening and weekend appointments.

There were no antenatal clinics held in the evenings or at weekends.

**Health promotion**

Health improvement information was available for women throughout the maternity unit. This included visual displays and leaflets about stopping smoking and alcohol in pregnancy.

We were told community midwives offered advice to women such as nutrition and exercise as required. They could provide contact details for additional support if this was needed.

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

Written consent was obtained from women prior to surgery and recorded clearly.

We reviewed five women’s notes that had surgery in the obstetric theatres. The consent forms had been signed and completed correctly.

Staff knew how to support women experiencing mental ill health.

Midwifery and medical staff were given information about mental capacity during their training. This included best interest decision making, the assessment process and how to record the decision. Staff we spoke with knew their responsibilities in terms of ensuring women had capacity to consent prior to invasive procedures.

**Is the service caring?**

**Compassionate care**

Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
When staff were speaking about women’s care, for example during the handover of care, they used respectful language.

**Friends and Family test performance**

**Friends and family test performance, percentage recommended (antenatal)**

![Graph showing Friends and Family test performance, percentage recommended (antenatal)](image)

Between July 2016 and June 2017 the trust’s Maternity Friends and Family Test (antenatal) performance (% recommended) was generally in line with the England average, ranging between 90% (April 2017) to 100% (September, October, November 2016)

March to May 2017 saw performance fall slightly below the England average, however as of June 2017 for antenatal care the trust’s performance was back in line with the England average of 96%.

**Friends and family test performance, percentage recommended (birth)**

![Graph showing Friends and Family test performance, percentage recommended (birth)](image)

Between July 2016 and June 2017 the trust’s Maternity Friends and Family Test (birth) performance (% recommended) was generally in line with the England average, ranging between 90% (April 2017) to 99% (February 2017)

March and April 2017 saw performance drop slightly below the England average but as of June 2017 the trust's performance for birth was back in line with the England average of 97%.
Friends and family test performance, percentage recommended (postnatal ward)

Between July 2016 and June 2017 the trust’s Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse than the England average, ranging from 85% (December 2016) to 97% (June 2016).

Only four of the 12 months in the period were either in line with or above the England average, but as of June 2017 the trust saw performance improve for postnatal ward to 97% above the England average of 95%.

Friends and family test performance, percentage recommended (postnatal community)

Between July 2016 and June 2017 the trust’s Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally worse than the England average.

All months in the period were below the England average, ranging from 83% (December 2016) to 95% (May 2017). As of June 2017 the trust’s performance for postnatal community was 93% compared to the England average of 98%.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of Maternity services 2015

The trust performed about the same as other trusts for all 16 of the questions in the CQC Maternity survey 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.42</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.22</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they</td>
<td>About the same</td>
<td>9.41</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Wanted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>8.88</td>
<td></td>
</tr>
<tr>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>8.86</td>
<td></td>
</tr>
<tr>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.13</td>
<td></td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.95</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.41</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.22</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.04</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.39</td>
<td></td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>6.97</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>6.86</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>8.10</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>7.73</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>About the same</td>
<td>5.77</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2015)

**Emotional support**

Staff provided emotional support to women to minimise their distress.

We saw staff were aware of women’s previous experiences and took this into consideration when they were interacting with them, for example a previous pregnancy loss.

There were plans to introduce a fetal loss clinic to help women through their next pregnancy.

The screening midwives provided counselling for women who had scans which revealed fetal abnormalities.

**Understanding and involvement of patients and those close to them**
Staff involved women and those close to them in decisions about their care and treatment. On the antenatal ward information was on display to inform women what would happen during the induction of labour, including a timeline.

A birth options clinic was available. The choice of place of birth was recorded in the women’s records. Any decisions to change this, for example if higher risk factors became present, were discussed with the women and their partners.

Women told us that staff explained the care and treatment they needed, any risks present and options or choices they could make.

Where possible there were open visiting times and families told us they felt welcomed by the staff.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. This included access to translation services.

However there was no signage in any other language than English. This was both in the main hospital and maternity unit. This did not full meet the needs of the population using the hospital service.

Bed Occupancy

Between 01/01/2016 and 30/06/2017 the bed occupancy levels for Maternity were generally lower than the England average, with the trust having 57% occupancy in Quarter1 2017/18 compared to the England average of 58.9%

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Meeting people’s individual needs
The service took account of women's individual needs. Specialist midwives attended antenatal clinic and provided support to those women with complex medical and social needs.

Specialist midwives provided both support and direct care to women using the service. Three midwives offered support for women with complex needs and three provided counselling during the screening stages. The specialist midwives attended a number of antenatal clinics to provide additional support for asylum seekers, those women with drug and alcohol dependency and diabetes. They were also available to offer support and guidance to the other midwives.

There were four midwives in the trust who provided support to those women aged 18 years and younger. They supported women through their pregnancy, accompanying them to clinic visits which had resulted in a good attendance rate.

A perinatal mental health clinic had started the week before the inspection. This was a weekly clinic and attended by specialist midwives, nurses and a consultant psychiatrist.

Translators were available for either face to face or telephone translation. Where possible staff who spoke the same language as the ladies would be allocated to their care.

The poster which displayed the helpline number contained the information in various languages. The friends and family poster was in 11 languages.

Access and flow

Women could access the service when they needed it. There was a system in place in the triage area to ensure women were seen within 15 minutes of arrival. A support worker would complete their observations and escalate any concerns which needed prompt attention. Information provided during the inspection was that in August 2017 630 women had been seen in this area and 98.5% were seen within 15 to 30 minutes. However of those women who required a review by a doctor, 45.1% were seen within 30 minutes which was worse than July when 77% had been seen in that timescale. The reasons for this were being investigated.

When a birth occurred in any unit, other than a designated birthing area, this was reported as an incident and investigated. Staff told us the learning from these were shared at the safety huddles and ward meetings. If necessary, information was also shared at a one to one level. The births outside a designated birthing area were recorded on the dashboard to identify any trends.

On the postnatal ward a system to assist the timely discharge of women had been introduced. This included two staff members assisting the doctors to prepare the records and patients for the New-born and Infant Physical Examination checks. A specific room had been set up to enable all equipment to be ready and reduce delays.

The average length of stay on the postnatal ward was 1.8 days. This had reduced since 2015 from 2.6 days.

Training had been provided for 15 band six midwives to be competent to administer intravenous antibiotics. Managers told us there were no delays in the administration of these medicines following this.

At the time of the last inspection the triage unit was relocated to the antenatal ward on a regular basis at night due to staffing. This had not happened since January 2017.

Staff had audited the waiting times of women in the antenatal clinics and found women could be in the clinic for four hours. Improvements included preparation the day before the clinic and a new audit was planned to assess the changes.

Learning from complaints and concerns
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, the trust’s timescale of 25 working days to investigate and close complaints was not being met.

Summary of complaints

Information for women about how to make a complaint was available in all wards and departments.

Between June 2016 and May 2017 there were 45 complaints about Maternity services (5.5% of all complaints).

The trust took an average of 65 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 11 complaints still open and yet to be completed.

There were 20 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 44%.

North Manchester General Hospital: there were 19 complaints (42.2%)
Royal Oldham Hospital: there were 22 complaints (48.8%)

There were five other complaints relating to maternity services in general.

(Source: Provider Information Request P55)

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Since the last inspection there had been a change in the senior management of the maternity unit. Staff told us this had a positive impact on the morale within the unit.

Staff of all grades knew who the senior midwifery managers were and said they saw them on the units, could discuss issues or concerns openly with them and had seen them providing practical support when required.

New managers and matrons had been introduced and this was seen as positive by the staff. This provided ward level leadership that was visible and they were aware of the issues in their department.

We were told there was improvement in the working relationships between staff in different areas of the maternity services. More joint initiatives, working across departments and visibility of managers from each department had helped this improvement. This had resulted in better communication between the departments and more effective joint working.

Vision and Strategy

There had been some uncertainty about the future of the maternity service at this site. Staff had thought they would be amalgamated with another NHS trust however this had not happened. Due to this some senior managers we spoke with talked about a lack of stability for the service. Action was being taken and one senior doctor was the link for a steering group and kept the doctors informed and involved in future plans.

The future plans included changes to the environment to better support the women. This included physical changes to the antenatal clinic to provide a more patient focused area.

Culture
Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us of an improvement in the culture within maternity services since the last inspection. This included changing from not wanting to continue working at the hospital to being proud to do so and feeling enthusiastic that they could provide a good service again.

All staff we spoke with described an open culture where they could discuss any concerns and felt comfortable and encouraged to do so.

Since the last inspection a culture of learning from other organisations had been developed. This included visits to other NHS trusts to review and learn from their practices, bringing experienced staff from other trusts to observe and support to enhance practice and meeting with experts in certain fields to obtain support for change.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

There had been improvements to the governance of maternity services since the last inspection. There was a clear governance structure and process for monitoring performance. Managers were clear about their roles and responsibilities within the system which included attendance at weekly and monthly meetings, providing information for reports and escalating any concerns through a clear process.

We found governance arrangements did not provide monitoring for all systems as the monitoring of practice such as the use of maternity early warning score records and one action as the result of an incident were not in place.

At the last inspection attendance at the mortality meetings was below the trusts’ target for consultants. At this inspection we were told this was still an area which needed improvement. The attendance by senior medical staff was not as good as expected due to not being able to release them from their practice responsibilities.

We were told the implementation of review of mortality had improved since the last inspection. This was now led by the governance lead, with more midwifery input and better junior doctor attendance. It was reported the lessons learnt and action plans were clearer and shared well with all staff.

Not all senior medical staff attended the divisional governance meetings due to practice commitments and a clash of timing with the medical education programme. This meant they were not present when performance was reviewed such as the information on the maternity dashboard.

Practice review meetings had been introduced twice weekly which were led by the on call consultant. These provided an opportunity to review the care of specific women, identify good practice and any issues where further training or changes in practice were required.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a meeting to discuss risks in maternity services on a weekly basis. This was compulsory for all unit managers and was attended by consultants. Incidents, complaints and learning from coroners cases were discussed. Root cause analysis reports were presented and changes in policy and practice agreed. Managers discussed how these meetings had improved joint working for improvement and communication about risks across maternity services.
At the last inspection the consultant with the lead responsibility for risk management did not have enough time to manage this process. At this inspection additional training and support had been provided to ensure staff who had such roles were provided with the necessary skills and knowledge.

There was a lack of clarity about how performance was measured, monitored and improved at the last inspection. Although improvements had been made in the processes these were not yet embedded. Not all senior midwifery or medical staff we spoke with were clear about the current performance and actions being taken. This included the information on the maternity dashboard and how this was used for improvement.

**Engagement**

The trust engaged well with women, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff told us they had felt involved in the changes which had taken place at ward level. This included discussions around what was working well and what needed to change before changes in practice and procedures took place.

There were several mechanisms in place to ensure ongoing staff engagement took place. This included newsletters, emails, notices in staff areas and discussions at safety huddles. Staff told us this had improved since the last inspection.

Each ward or department had a monthly meeting. Although in some areas we were told attendance was not as high as the managers would like this was seen by staff as an opportunity to discuss any issues and keep abreast of changes. These meetings were open to staff of all grades.

We observed staff asking women and their partners for their feedback about their experiences while on the unit. This included completing friends and family and other feedback forms.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong and promoting training. There were examples of how a culture of learning from others had been introduced.

Since the last inspection some senior medical and midwifery staff from a neighbouring NHS trust had been working alongside staff at this hospital. This had been seen as a positive action, with support for improvement being offered and good practice being shared. Examples were given of where this joint working had led to improvements which included the use of the World Health Organisations safer surgery checklist in theatre and the application of various guidelines. The level of this support had reduced to them being present on average of twice weekly with a view to being withdrawn completely.

The next phase of continuous improvement and joint working was that five consultants from this hospital would work alongside colleagues at the neighbouring hospital. They had four work streams to review with the aim of introducing additional antenatal clinics. This included obesity and peri-natal mental health clinics.

A system of practice reviews had been introduced. This meant themes and trends were identified through the review of cases and changes to policy resulted. Examples of this included changes to guidelines about use of fluids and identification of a rise in the use of general anaesthetics in caesarean sections.

A bleep had been provided to the manager who was in charge and responsible for the staffing oversight. This had improved their availability to other staff.
Services for children and young people

Facts and data about this service

The trust has 104 inpatient paediatric beds across two sites – North Manchester General Hospital and The Royal Oldham Hospital. The 104 inpatient beds include 56 Neonatal and 3 HDU beds. In addition to the inpatient beds across two sites, the trust also provides paediatric outpatient services at Fairfield General Hospital and Rochdale Infirmary. 
(Source: Routine Trust Provider Information Return (RPIR) – Beds tab)
The trust had 16,602 spells between June 2016 and May 2017.

Emergency spells accounted for 92% (15232 spells), 4% (687 spells) were day case spells, and the remaining 4% (683 spells) were elective.


![Percentage of spells graph]

Total number of children’s spells by site, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Oldham Hospital</td>
<td>8,339</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>8,214</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>49</td>
</tr>
<tr>
<td>This trust</td>
<td>16,602</td>
</tr>
<tr>
<td>England Total</td>
<td>1,100,894</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

Mandatory training

The service provided mandatory training across a number of areas which were based on key skills for both nursing and medical staff. Most staff had completed this training but it varied over disciplines. The trust set a target of 90% for completion of mandatory training.

Mandatory training completion rates

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:
(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s
Division, this therefore includes staff that work in other services, such as maternity, as well as those working in children’s services.

Medical and dental staff in the Women’s and Children’s division met the 90% target for mandatory training compliance for three modules only. Basic life support training had the lowest compliance levels with only 60% of eligible medical and dental staff having been trained.

Nursing and midwifery staff in the Women’s and Children’s division met the 90% target for mandatory training compliance in five modules and were over 80% compliant in twelve of the eighteen modules.

Both waste management and infection prevention (non patients) achieved 100% compliance, however the requirement for eligible staff members for these modules was very low with only one and two members respectively eligible for training in these areas. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training).
Safeguarding

We found that children’s services staff understood how to protect patients from abuse and the service worked well with other agencies to do so. A new safeguarding team, with new leadership, had recently been put in place across the trust. The new internal structures seemed to be having a positive impact of changing and improving the safeguarding practice within the trust.

The leadership in the trust’s safeguarding team had recently become involved in a group model of support with Salford Royal Hospital.

The new model for safeguarding had been developed as part of the new integrated care model which the trust is in the process of introducing.

The two organisations had combined their knowledge bases and we were told this had been beneficial to both parties in terms of sharing learning and developing new structures for safeguarding in the future.

We found there were trust wide safeguarding policies and procedures in place in children’s services. The staff in the service knew how to access internal policies.

The structure for reporting on safeguarding concerns was clear and concise and the staff knew what to do with safeguarding concerns they might have. Any major issues would be escalated to lead nurses, doctors and service leads and then, if need be, to the trust safeguarding team or the local authority social care team.

Staff across the service were able to give examples of the types of safeguarding concerns they had faced, how they were reported and also provided us with examples of positive outcomes in the protection of children.

We were told by staff that they consulted with each other on safeguarding concerns, particularly if children were going to be moved to another ward on site. We found that teams worked together to provide continuity of care and act as a resource for each other when needed.

We were given an example where a lead nurse provided on-going support to staff in another department after a difficult safeguarding situation. The nurse had made a positive bond with the child and left her own department to support the child’s transfer on to another ward. The continuity of care continued the following day when the nurse visited the child again on the ward.

The child was sent home with a support package in place after they were reviewed by mental health services and social care.

There was a multi-agency approach to dealing with concerns, including sharing information with other services i.e. multi-agency panels, child in need meetings and social care teams and where necessary the police.

Consideration was given to the increased risk that parental issues might have on children. The staff were able to highlight the potential risk that parental substance misuse, mental health issues or domestic abuse could represent to children.

Arrangements were in place to safeguard and refer victims of sexual assault and abuse. The services also had a pathway in place for Child Sexual Exploitation and a pathway for victims of Female Genital Mutilation.

A serious case review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The review looks at shared lessons that can help prevent similar incidents from happening in the future across services.

The children’s service were linked into the reviewing process and participated in learning from Serious Case Reviews. We found no criticism or concern about children’s services in any of the reported Serious Case Reviews which North Manchester General Hospital had taken part in.

We found that a lessons learnt bulletin for Serious Case Reviews had been developed internally to share information and learning across the hospital. Arrangements were also in place to collect data for the use of safeguarding boards and local authorities.

All staff had access to Royal College of Nursing paediatric guidelines 2016-2018 through the
The guidelines are a tool which highlights different types of safeguarding concern and direct staff to actions to be taken in the event of harm or abuse of children. The guidelines also described the correct discharge process to be undertaken where safeguarding risk was present.

Multi-agency work was effective when it occurred with other services. However, the staff voiced some concern regarding the response times of mental health services.

A member of staff gave an example of a child being left on the children’s ward as a place of safety and described nursing staff having difficulty gaining initial support from children’s mental health services. The member of staff was clear that this delayed response was due to lack of capacity, rather than intention by the mental health practitioners. The child waited in hospital for eight hours before an assessment was made.

In a review of recorded incidents by children’s service staff, we found an incident that had occurred on 09/08/2017 on the Koala unit relating to a delay in access to mental health service.

Level 3 safeguarding adults training rates across both disciplines were relatively high even though the service was not adult focused. The training enabled staff to identify vulnerable adults who were parents. Staff could then seek additional support to enable parents to better meet the needs of the children in their care.

We received a breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing,midwifery staff in the Women’s & Children’s Division.

The trust set a target of 90% for completion of safeguarding training at both level 2 and level 3. The 90% compliance target was met for one of two safeguarding modules by nursing staff in the Women’s & Children’s division at the trust. Level 2 children’s training for nursing staff was achieved with 98.2% compliance rates. The second module, level 3 training compliance for nursing staff was lower at 82.5%.

We were given information for medical staff safeguarding completion rates in October 2017.

Medical staff in children’s services had improved in both the level 2 and 3 safeguarding modules. We found medical staff in children’s services reached 100% compliance in safeguarding level 2 and improved compliance in Safeguarding at Level 3 to 84%.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing,midwifery staff in the Women’s & Children’s Division is shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services)
Nursing and midwifery staff in the Women’s & Children’s division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We found that overall the service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The CQC children’s survey showed that the trust’s children’s services were rated on average the same as other trust of its size by parents in terms of cleanliness.

CQC Children’s Survey 2014 – Q26

In the CQC children’s survey 2014 the trust scored 8.84 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. (Source: CQC Children’s Survey, RCPCH).

On inspection, we found children’s services used the trust wide infection prevention and control policy. Staff were aware of current infection prevention and control guidelines.

Staff were provided with training in hand hygiene and infection control.

Nursing and midwifery staff in the Women’s & Children’s Division s were well over the 90% compliance training rate for infection prevention and control.

Nursing and midwifery staff in the Women’s & Children’s Division were also well over the 90% compliance training rate for hand hygiene training.

However, medical staff in the Women’s & Children’s Division were well below the 90% compliance rate for infection prevention and control. Medical staff in the Women’s & Children’s Division were also below the 90% compliance rate hand hygiene training.
Whilst we were onsite we found staff worked according to best practice guidelines and followed ‘bare below the elbows’ guidance. We observed staff washing their hands between seeing patients and saw posters which were visible on walls showing cleanliness direction.

The trust had devised an infection control video for staff and patients, which could be found on its website.

In our last inspection report in 2016, we found that the trust had no evidence of any audits relating to infection control in its children’s services. However on this inspection we found evidence that audits had been undertaken and audit results were published for children’s services.

The trust undertook a number of cleanliness, infection control and hygiene audits across North Manchester General Hospital. We were provided with infection control hygiene for July, August and September 2017 for its children’s services. The children’s services were audited on hand hygiene, Personal Protective Equipment and overall hygiene policy compliance.

Wards and units were generally 100% compliant with the audits; however we found some variation in performance in certain months.

Clinical areas and waiting areas were visibly clean and well maintained.

Visitors to units had access to alcohol based hand gel at the entrances with instructions on how to apply the gel. All hand gel dispensers were full and ready to use and were located in various places around the buildings.

The rooms had hand washing facilities and paper towels for drying hands.

Trust wide internal arrangements were in place for managing waste and handling clinical specimens.

Staff had access to appropriate personal protective equipment, such as gloves and aprons.

Environment and equipment

We found that overall children’s services had suitable premises and equipment and looked after them well.

All the sites were suitably maintained. The services were situated within multi-purpose buildings across four sites.

The wards and units had good access; lifts were available to access the building for individuals with mobility problems.

All ward spaces, units and outpatient areas had suitable entry and exit controls. The controls were used to ensure children were safe.

All ward spaces, units and outpatient areas had trained staff observing and covering those areas.

The waiting areas enabled reception staff to have private discussion with patients and carers. The reception areas were visibly clean and maintained to a good standard.

The consultation rooms, wards spaces and units in children’s services were suitable for the treatments and diagnosis carried out in those areas. We found the clinic areas and patient areas were visibly clean and maintained to a good standard, as were the waiting areas.

At the time of our inspection we found waiting areas in outpatients could become overcrowded and busy, especially in the late afternoons or when morning clinics were in progress. In a small number of instances we observed parents standing for periods of time before accessing treatment because of the lack of seating.

Single-use, sterile instruments (such as needles and swab packs) were stored appropriately and when we checked they were within the manufacturers’ expiry dates.

Resuscitation trolleys were tagged and secured appropriately on every site.
In our last inspection report in 2016, we highlighted that equipment maintenance was poor with over 50% of items having not been checked or verified as being checked by the trust.

In this inspection, the trust supplied us with information that showed us that 90% of all equipment was serviced within 3 months of the due date.

We did several spot checks across all equipment including electronic equipment. Items were clean and tags attached to items evidenced that appliances had been tested. We were able to review a service log of equipment checks in children’s A&E. We found equipment logs to be satisfactory including defibulator testing.

Fire extinguishers had been reviewed, checked and were in date.

We were told by staff there were on going health and safety checks of the clinic rooms and clinical areas. Staff were asked to report any action required and if necessary the issue was flagged via the incident reporting system if necessary.

Anaphylaxis emergency medicine was available as were emergency kits.

Cylinders of oxygen were present and were checked regularly and stored securely.

The below graph shows that parents rated the children’s services on average about the same as other trusts in England in terms of safety and quality of equipment.

CQC Children’s Survey 2014 – Q2, Q7, Q25

In the CQC children’s survey 2014 the question ‘Did you feel safe on the hospital ward?’ was not applicable to the trust.

The trust scored 8.89 out of ten for the question ‘Did you feel that your child was safe on the hospital ward?’ This was about the same as other trusts.

The trust scored 8.57 out of ten for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’

This was about the same as other trusts.

A list of all scores from the survey which fall under the safe domain is listed below.

<table>
<thead>
<tr>
<th>CQC Children’s Survey questions, safe domain, The Pennine Acute Hospitals NHS Trust</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Did the ward where your child stayed have appropriate equipment or adaptions for your child?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>8.57</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26. How clean do you think the hospital room or ward was that your child was in?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>8.84</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>53. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>9.77</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>7. Did you feel that your child was safe on the hospital ward?</td>
<td>S3</td>
<td>0-7 Adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2. Did you feel safe on the hospital ward?</td>
<td>S3</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Assessing and responding to patient risk

Medical review information was provided via the use of Paediatric Bedside guidelines which staff accessed on the internal intranet. The guidelines gave examples of treatment pathways for all
paediatric presentations within North Manchester General Hospital and were dated 2016-2018. Children’s services had suitable ways of assessing and responding to patient concern through its bedside guidelines. The level of seniority of the reviewer for patients was dependent on the risk the child presented and the state of deterioration. The higher the risk, the higher the escalation process.

The service used the Manchester Children’s Early Warning Score (MANCHEWS). MANCHEWS is a tool to identify early warning signs of deterioration in a patient’s health.

MANCHEWS use had been identified as an area for improvement in our last inspection of children’s services in 2016. The trust had taken some action to address this issue and developed an audit process to monitor MANCHEWS but we found more work needed to be done to improve compliance.

MANCHEWS were reviewed as part of a Paediatric Escalation and Care Quality audit undertaken between October 2016 and January 2017.

The children’s services did not hit the rate of compliance for MANCHEWS which was set at 100%. The service’s performance was 90% of all Early Warning Score (EWS) were graded accurately in the 60 records examined.

Nursing staffing

We found the service struggled with the number of full time nursing staff who had the right qualifications, skills, training and experience.

However, the staff kept people safe from avoidable harm and abuse and provided the right care and treatment. Nurse staffing numbers in post were less than children’s services had planned for and staffing pressure was a concern.

The table below shows that between December 2016 and May 2017 there were less nurses on duty across Pennine trust’s children’s services than had been planned for. The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in children’s services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>209.85</td>
<td>232.58</td>
</tr>
<tr>
<td>January 17</td>
<td>210.81</td>
<td>232.58</td>
</tr>
<tr>
<td>February 17</td>
<td>212.81</td>
<td>232.58</td>
</tr>
<tr>
<td>March 17</td>
<td>214.98</td>
<td>232.58</td>
</tr>
<tr>
<td>April 17</td>
<td>211.54</td>
<td>232.58</td>
</tr>
<tr>
<td>May 17</td>
<td>213.50</td>
<td>231.58</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

To review the impact of staffing against safety, we asked the trust to provide a seven day snapshot of safe staffing numbers across the children’s ward and neonatal ward for the week commencing 23 October 2017.

We also asked for any incidents of harm that had occurred in that week to ascertain if the numbers of staff had an impact on safety.

We found the number of full time nurse and health care staff actually on shift were usually fewer
than had been planned on both day and night rotas in every service. The service had to fill the
gaps with agency or bank staff or other staff transferred from departments. The gaps were due to
sickness, leave or vacancies.

However in some of its wards and units, children’s services had on average more full time staff
on shift in comparison to other departments in the hospital.

The neonatal department had most staffing pressure and at the time of our inspection was trying
to recruit needs to new posts.

The neonatal department had 68% of the nurses on day duty that it had originally planned. The
hospital average for day shifts was 85%. The neonatal department therefore had less nurses on
day duty than the hospital average.

The neonatal department had 73% of the nurses on night duty it had originally planned. The
hospital average for night shifts was 89%. The neonatal department therefore had less nurses on
night duty than the hospital average.

The children’s ward fared better and had 81% of the nurses on day duty that it had originally
planned for. The hospital average for day shifts was 85%. The children’s ward therefore had less
day duty nurses than the hospital average.

The children’s ward had 84% of the night nurses it originally planned for. The hospital average on
night shifts was 89%. The children’s ward therefore had fewer night nurses than the hospital
average.

The children’s services collectively generally had less health care support staff on duty than it
had planned for in both night and day shifts.

Whilst the numbers of full time nurses and healthcare staff were less than planned in the week,
we found that the Koala unit, neonatal and children’s wards did not have any harm incidents in
the period.

We also found that reported staffing incidents were low across children’s services in the period
June 2017 and October 2017 despite the lack of planned staff.

16 incidents were staff related out of a total of 127 in that 5 month period of time and none of the
incidents were classed as serious.

The information showed that although children’s services had lower than expected nurse staffing
levels it did not have an impact on patient safety or quality of care.

**Nursing and Midwifery Vacancy rates**

The children’s services had low nursing and midwifery vacancy rates.

Its vacancy rates were less than its counterpart children’s services at Royal Oldham Hospital and
across other parts of the trust.

The department had a nursing and midwifery vacancy rate of 3.9%, which compared favourably
with Royal Oldham’ vacancy rate of 9.4%.

Between June 2016 and May 2017, the trust reported an average vacancy rate of 8.8% for
nursing and midwifery staff in children’s services;

- North Manchester General Hospital: 3.9%

(Source: *Routine Provider Information Request (RPIR) P17 Vacancies*)

**Nursing and Midwifery Turnover rates**

The children’s services in North Manchester General Hospital had low nursing turnover rates. Its
turnover rates were less than its counterpart children’s services at Royal Oldham Hospital and
across the trust.
Between June 2016 and May 2017, the trust reported an average turnover rate of 1.1% for nursing and midwifery staff in children’s services.

- North Manchester General Hospital: 0.9%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Nursing and Midwifery Sickness rates

Between June 2016 and May 2017, the children’s services in North Manchester General Hospital had slightly higher nursing sickness rates than its counterpart children’s services at Royal Oldham Hospital. The rate of sickness was also higher than the trust target for sickness which was 4.6%.

The trust reported an average sickness rate of 6.7% for nursing staff in children’s services, which is above the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 7.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

We found that the lead paediatric consultant had set about increasing medical cover across North Manchester General paediatric services. Low numbers of clinical staff were highlighted by the CQC as a concern in 2016.

The consultant lead felt the trust had listened to the CQCs concerns and given the service the ability to recruit to new medical posts through vacancies. The service had recruited to three new consultant posts in the last year.

All data we collected showed that the medical staffing situation in the children’s services had improved significantly since our 2016 inspection.

Nurses and medical staff stated that they had seen significant improvement in medical cover. Staff felt that the increases had made a significant impact on patient care and the ability of wards and units to carry out their roles.

In the last year, June 2016 to May 2017, children’s services have seen a reduction in the shifts covered by agency medical staff in its consultant and middle grades.

Consultant shifts covered by agency staff have reduced from 12 in June 2016 to only 6 in May 2017. The reductions showed that full time staff rather than locums or agency staff were covering shifts.

Middle grade staffing has also been affected. We saw evidence of a drop in the use of middle grade agency and bank staff from 9 in June 2016 gradually decreasing to only 1 in May 2017.

The reduction in middle grade agency and bank staff indicates that the service had the capacity to cover most of its services with its own full time staff

The peak time for children’s services was around 5pm and good practice highlighted the need for consultant expertise in and around this time both to cover capacity and the expertise needed to make decisions.

In our last inspection we were concerned about the peak shift times that consultants covered the children’s services and their general shift patterns. During this inspection we found consultant presence at peak times had improved as new consultants had been employed on new contracts which targeted peak time cover.
The lead consultant in paediatrics told us that the consultant rota was now “well-staffed” with consultant cover from 9am until 11pm then out of hour’s arrangements.

Neonatal service’s had similar cover arrangements with its own rota.

Paediatric services in North Manchester General Hospital were covered every day and evening, every week by paediatric junior doctors who provided first response to high risk incidents.

We also reviewed the trust’s planned medical staff compared to actual numbers of medical staff employed in children’s services for the period December 2016 to May 2017. The service had generally the same numbers in post compared to those who were planned.

Data on vacancy rates, sickness and turnover rates for medical staffing showed better average rates when compared to Royal Oldham Hospital and the trust.

The trust reported the following planned and actual staffing figures for medical staff working in children’s services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>54.40</td>
<td>55.50</td>
</tr>
<tr>
<td>January 17</td>
<td>53.40</td>
<td>55.50</td>
</tr>
<tr>
<td>February 17</td>
<td>53.40</td>
<td>55.50</td>
</tr>
<tr>
<td>March 17</td>
<td>53.40</td>
<td>55.50</td>
</tr>
<tr>
<td>April 17</td>
<td>53.80</td>
<td>55.50</td>
</tr>
<tr>
<td>May 17</td>
<td>53.80</td>
<td>55.50</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Medical Vacancy rates

Between June 2016 and May 2017, the children’s services had no vacancies in its medical establishment.

The services counterpart in the trust Royal Oldham Hospital had a 3.1% vacancy rate. Between June 2016 and May 2017, the trust reported an average vacancy rate of 2.4% for medical staff in children’s services:

- North Manchester General Hospital: -1.0% vacancies due to over establishment of medical staff.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Medical Turnover rates

Turnover rates were low for medical staff in children’s services.

Between June 2016 and May 2017, the service had an average turnover rate of 1.7 %. The department’s counterpart children’s service in Royal Oldham Hospital had a 3.5% turnover rate.

Between June 2016 and May 2017 the trust reported an average turnover rate of 2.6% for medical staff in children’s services:
• North Manchester General Hospital: 1.7%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Medical Sickness rates

Sickness rates were low for medical staff in children’s services.
Between June 2016 and May 2017 the average sickness rate amongst medical staff in all the trust children’s services was 0.6%.
The sickness rates were lower that the trust overall sickness rate target of 4.6%
The trust reported an average sickness rate of 0.6% for medical staff in children’s services which is better than the overall trust target of 4.6% for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May and 31 May 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average whilst the proportion of junior (foundation year 1-2) staff was higher.
However, middle grade and junior grade staff reported to be working at the trust was higher than the England average.
The trust had recruited two new consultant grades in the last year in North Manchester children’s services to increase consultant cover, which should significantly improve the balance between consultant and junior staff.

Staffing skill mix for the 89 whole time equivalent staff working in Children’s services at The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Records

We found that overall children’s services staff needed to improve its record keeping. The trust had recently undertaken a review of medical notes and compliance was generally poor.
The trust used an electronic recording system and notes based system in tandem.
North Manchester General Hospital follows Pennine Acute Hospital NHS Trust – Clinical Record Keeping Policy and Essential Clinical Record Keeping Standards. GMC Guidance “Good Medical Practice” (2014)
The trust had reviewed 60 notes in North Manchester Children’s services as part of a Paediatric Escalation audit between October 2016 and January 2017. The audit was marked by way of traffic lights system of green, amber, and red.

The outcomes of the records audit were mixed. The service hit green 100% compliance in only 3 areas. The service hit amber 94%- 79% compliance in 6 areas and was red under 65% in 7 areas.

However, we looked at six sets of records whilst on site and the notes were generally clear, up-to-date and available to all staff providing care.

We found that in the year previous to our inspection the trust had only 0.2% of its outpatients (which includes paediatric outpatient services) seen without records.

**Medicines**

We found that overall children’s services prescribed, gave, recorded and stored medicines well but prescribed incidents sometimes occurred. Patients usually received the right medication, at the right dose, at the right time and this was recorded properly by staff.

The trust had a medicines management policy, dated 11 October 2017, which was used by children’s services.

We looked at the incident logs to ascertain if medication incidents were high in number. The trust had recorded 16 medication incidents from June 2017 up until October 2017 in its North Manchester children’s service. The number was in line with the trust’s other children’s service in different areas in proportion to its size.

The incidents severity were low and we found that over all the 16 incidents were classed as no harm outcomes by staff. We found there was no discernible pattern in terms of the incident cause or where they occurred.

Medication incidents were therefore not at high levels, not of high risk and staff reported incidents when appropriate.

The children services had regular medication audits and staff told us they had close links with pharmacy.

The trust provided us with a years’ worth of pharmacy audits which were undertaken in three of the departments in children’s services. We found in the most recent audit dated September 2017, overall compliance was 100% for neonatal and the Koala unit.

However the children’s ward audit scores were 78% which was below the 100% compliance target expected by the trust.

On reviewing historical data in the last year we found children’s services generally failed to hit its target of 100% compliance in its medication audits across its departments.

The service failed to achieve compliance in one specific area of audit, namely fridge temperature checks. We found this occurred across all its departments on a regular basis in the period between June 2017 up until October 2017.

The issue of keeping fridge temperature recordings in line with recommended temperatures had been highlighted in our last inspection in 2016. Whilst this was the case we did not find any evidence of fridge temperatures being out of line during our inspection.

Whilst on inspection we checked two controlled drugs cabinets on the children’s ward and on the paediatric A&E. We found that the medicines were stored correctly and locked up safely in both cabinets.

We found one inconsistency regarding the counting of controlled drugs in the cabinet. Two controlled medicines books in the same cabinet were being used on the children’s ward. Staff
explained that they had not taken out an old book which had recently become full and it had been left in the cabinet with a new one. Once the duplication was highlighted to staff, the old book was placed in safe storage.

Incidents

Never Events

We found that the service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. We found that between August 2016 and July 2017, the trust reported no incidents which were classified as never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

The trust has 3 hospital sites where children’s services are based and none of these incidents occurred in North Manchester children’s services. There were therefore no serious incidents (that led to patient harm) or patient deaths reported during this period in this service.

We found there were corporate policies and procedures that guided staff on the reporting of any incidents or concerns, investigation and learning procedures. These policies and procedures were available to staff through the provider’s intranet and staff knew about them.

The trust had recently installed a new electronic incident reporting system. Staff were aware of the system and had been trained in how to use it to report incidents.

Hospital Standardised Mortality Ratio (HSMR) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths. The HSMR rates for paediatric services in North Manchester General showed ten deaths since November 2016.

The number of incidents which occurred in North Manchester children’s services between June 2017 and October 2017 were not of high volume.

The vast majority of the 127 incidents in the service were classified as low or insignificant with only one being classified as moderate. The incidents did not lead to any significant harm for patients or staff.

North Manchester children’s services accounted for approximately 127 of the 254 incidents which was approximately 50% of all incidents recorded. The service had more incidents than other children’s services in the trust but this was relative to its size.

We found that North Manchester General children’s services had no identifiable trends or themes from the incidents reported across its services. The three types of clinical incidents which had been recorded as occurring more than any other in the June 2017 and October 2017 period were; general communication 13, medicines 16 and staffing 16.

The number of staffing incidents between June 2017 and October 2017 was low. Staffing incidents made up approximately 13% of all incidents recorded in that period. Staff felt the service was safer and more responsive as a consequence of better staffing numbers since our last inspection in 2016.

The staff understood the incident reporting procedures and gave examples of the types of
incidents they would report. Staff understood duty of candour and were able to explain why it was important.

Safety thermometer

The service used safety monitoring results well. The trust collected safety information and shared it with staff, patients and visitors. Information collected was used to improve safety.

We found an incident report log was kept by the children’s services so that the number of and severity of incidents could be reviewed by managers and staff.

Staff told us they received verbal feedback about incidents they reported and that this was used to improve practice and the service to patients.

The trust had a Lessons learnt bulletin which it evidenced to us. The bulletin was developed as a means to share lessons learned from reported incidents to improve safety.

We saw evidence whilst we were on site that incidents and concerns were discussed during routine staff meetings and safety huddles.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or catheter urinary tract infections between July 2016 and July 2017 for its children’s services. *(Source: NHS Digital)*

Major incident awareness and training

The service planned for emergencies and staff understood their roles if one should happen. The trust had a major incidents policy which we had sight of.

The children and young people’s service had recently had to deal with a number of casualties following a major incident in Manchester city centre.

Staff felt the service dealt with the incident positively and staff felt supported.

Is the service effective?

Evidence-based care and treatment

The service recently audited itself using Facing the Future: Standards for Paediatric Services which outlines 10 minimum standards for acute, general paediatric care. Facing the Future outlines best practice. The standards reflect the level of support which children and their parents and carers should expect from the doctors looking after them. The standards are defined by the Royal College of Paediatrics and Child Health (RCPCH).

The service audited itself on 8 of these standards which included general medical cover, handovers and review processes.

The service hit 100% in 6 of the 8 standards. An example of these successful compliance standards were consultant cover at peak times and at least 1 consultant led handover every 24hrs.

The service failed to hit the 100% compliance rate for 2 standards which were middle grade
review in 4 hours, in which it scored 72% and a consultant review in 24 hours hitting 62%. The service has developed an action plan to improve on the two areas of none compliance.

A Paediatric Escalation and Care Quality audit was undertaken between October 2016 and January 2017 to look at the service’s management of escalation of risk and the quality of care delivered by children’s ward.

The Paediatric Escalation and Care Quality audit was marked by way of traffic lights of green, amber, and red, which was denoted as poor. The results summary showed mixed outcomes.

- The service hit green i.e. 100% compliance in only 3 areas of the audit.
- The service hit amber i.e. 94%-79% compliance in 6 areas of the audit.
- The service hit i.e. red under 65% in 7 areas of the audit.

During the Neonatal Directorate Quality and Performance Meeting in October 2017, it was identified that 11 of the guidelines had expired and that three guidelines were about to expire. The minutes of the meeting did not detail actions and it was not clear whose responsibility it was to review and update the guidelines or any time lines for completion.

**Pain relief**

Staff and the service managed pain well. The service followed policies and practices which reduced pain to patients. Records showed pain scores were recorded appropriately.

Pain was manged well through medication when necessary.

The staff on children’s wards had access to a specialist pain management team in the hospital if required.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

The children’s services used a malnutrition screening tool to evaluate food and drink intake on children’s records.

We found that staff used special feeding and hydration techniques when necessary.

The service made adjustments for patients’ religious, cultural and other preferences and provided appropriate food for both patients and carers. An example of this is a service named “Ezra” which provided kosher food in the hospital.

The hospital provided nutritional support for children with additional nutritional needs through its department of nutrition and dietetics. The support was provided through liaison with the neonatal unit, children’s wards and outpatients department as needed.

**Patient outcomes**

We found the service monitored the effectiveness of care and treatment and compared local results with those of other services. The service had put a number of audits in place to measure compliance to national guidelines and show learning from audit results.

Data we received showed that patient outcomes were generally at the England average. However; in some cases patient outcomes were mixed and lower than the England average.

**Paediatric diabetes audit 2015/16**

Data we received showed that the hospital had England average outcomes in the National Paediatric Diabetes Audit 2015/16. Whist the trust had England average outcomes in the audit
Paediatric Diabetes Audit, it had improved on the outcomes from the previous year.

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”. The data below shows that in the 2015/16 diabetes audit North Manchester General Hospital performed similar to the England average.

The proportion of patients receiving all key care processes annually was 29.9% which was within the expected range, compared to a national aggregate of 25.8%. The previous year's score was 5.5% showing the trust had improved with regards to this metric.

The average HbA1c value (adjusted by case-mix) at the trust was 70.8 which was within the expected range, compared to a national aggregate of 68.3. The previous year's score was 74.1

The median HbA1c value recorded amongst the 2015/16 sample was 67%, which was better than the previous year’s median of 69%. (Source: National Paediatric Diabetes Audit 2015/16)

Emergency readmission rates within two days of discharge

We received data that indicated that the emergency readmission rate (within two days) was generally lower than the England average when it was compared to other trusts for 1-17 year olds. The trust therefore performed better than average and you were less likely to be re admitted as an emergency in the 1-17 year old age range.

We received data that indicated that the emergency readmission rate (within two days) was slightly higher than the England average when it was compared to other trusts for under 1 year olds. However, it was not significantly higher. The trust therefore performed slightly worse than the England average. Children had a slightly higher chance of returning to hospital as an emergency admission if you were under 1 year old.

Readmission rates were slightly higher than the England average, but not significantly higher, for the age range 1-17 year olds when compared against readmissions for general surgery.

The tables below show the percentage of patients (by age group) who were readmitted following an elective admission. The tables show only those specialties where six or more readmissions were recorded are shown in the table.

<table>
<thead>
<tr>
<th>Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment specialty (February 2016 to January 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were emergency readmissions after elective admission at The Pennine Acute Trust among patients in the under 1 age group between February 2016 and January 2017. However no treatment specialty reported six or more readmissions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty (February 2016 to January 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were emergency readmissions after elective admission at The Pennine Acute Hospitals NHS Trust among patients in the 1 to 17 age group between February 2016 to January 2017. However no treatment speciality reported six or more readmissions.</td>
</tr>
</tbody>
</table>

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission.

Children’s services had similar percentage of under 1 year olds readmitted following an emergency admission in paediatrics when compared to the England average. The data was taken between February 2016 and January 2017.
Children’s services had a similar percentage of patients aged 1-17 years old readmitted following an emergency admission in paediatrics when compared to the England average.

The service had a slightly higher percentage of 1-17 year olds readmitted following an emergency admission in general surgery when compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Pennine Acute Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.7%</td>
<td>5,875</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2.3%</td>
<td>8,965</td>
</tr>
<tr>
<td>No other specialty at the trust had six or more readmissions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

Between March 2016 and February 2017 the trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and diabetes, but was in line with the England average for the percentage of patients aged 1-17 years who had multiple readmissions for epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>The Pennine Acute Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>17.3%</td>
<td>504</td>
</tr>
<tr>
<td>Diabetes</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>22.7%</td>
<td>75</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>7</td>
</tr>
<tr>
<td>1-17</td>
<td>27.2%</td>
<td>81</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’. (Source: Hospital Episode Statistics, provided by CQC Outliers team)
Other CQC Survey Data

National Neonatal Audit Programme

In the 2016 National Neonatal Audit the trust’s performance was as follows:

North Manchester General Hospital:

Retinopathy of Prematurity (ROP) is a disease that occurs in premature babies. It causes abnormal blood vessels to grow in the retina. The disease can cause the retina to detach from the back of the eye, leading to blindness and neonatal units screen babies for the disease.

The hospital performed at the England average when its Retinopathy of prematurity screening figures were compared against other trusts.

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 47 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening.

98% of these babies were screened on time in accordance with the NNAP extended screening window.

This was equal to the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

Documented consultation with parents by senior medical staff is deemed as best practice in paediatric services. Facing the Future: Standards for Paediatric Services outlines 10 minimum standards for acute, general paediatric care.

Documented consultation with parents by a senior member of the neonatal team within 24 hours of admission is one of the standards. The standards are intended to support a safe and effective service for children and young people.

Data showed that the trusts children’s services performed significantly worse than the national average for the first consultation.

There were 372 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from the analysis.

The first consultation following admission occurred within 24 hours for 66% of the eligible episodes in children’s services.

This was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

The hospital recorded less data than other hospitals nationally on the normal survival rate at two years old. Data was entered for 24% of the babies assigned to the unit, whilst nationally data was
There were 37 babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to this hospital for two year health assessment based on their final neonatal discharge.

Data was entered for 24% of the babies assigned to the unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July 2013 and June 2014.

**What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?**

Bronchopulmonary dysplasia (BPD) is a form of chronic lung disease that mostly affects children who are premature and infants. It occurs by mechanical ventilation (respirator) and long-term use of oxygen.

**Definition of Bronchopulmonary Dysplasia:**

A: Mild: respiratory support (Ventilation ,CPAP, BiPAP, HHFNC and or any oxygen) on day 28 + air at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

B: Significant: respiratory support on day 28 + respiratory support at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

There were 90 babies born < 32 weeks in this hospital who were included in the analysis for Bronchopulmonary Dysplasia.

Of these babies 17 were identified as having Significant BPD.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance but some staff said they did not receive clinical supervision.

**Appraisal rates**

Between June 2016 and May 2017, 83% of staff working within services for children and young people within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 90%.

The 83% appraisal rate applies to nursing and midwifery registered, administrative and clerical and additional clinical services staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At North Manchester General Hospital 87% had received an appraisal.

The figure for staff in neonatal was lower at 79%.

(Source: Trust Provider Information Request P46)

**Multidisciplinary working**

We found that staff of different kinds worked together as a team to benefit patients in children’s services.

We found a good and comprehensive multi-disciplinary approach to working.

Children and young people had access to a number of professionals from both medical and none medical backgrounds.
The patients had access to staff which included consultants, junior doctors, nurses and nurse specialists. The patients also had access to other healthcare staff which included physiotherapists, dietitians, speech and language therapists, learning disability nurses, occupational therapists, play therapists and alcohol workers. Doctors, nurses and other healthcare professionals told us they supported each other to provide good care. Data we collected showed that parents agreed.

In the CQC children’s survey 2014 the trust scored 8.14 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

**CQC Children’s survey 2014 – Q36**

In the CQC children’s survey 2014 the trust scored 8.14 out of ten for the question ‘Did the members of staff caring for your child work well together?’

This was about the same as other trusts. *(Source: CQC Children’s Survey, RCPCH)*

### Seven-day services

The neonatal unit, children’s ward and Koala unit were open 24 hours a day, seven days a week

### Access to information

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

Staff used electronic records to record patient information.

Staff had access to computer terminals and had passwords to open and lock computers access.

Policies and procedures were kept on the trust’s intranet page and staff knew where to access them.

Discharge summaries and discharge letters were provided to GPs who provided primary care health services to patients.

Data we received from the CQC Children’s survey showed that parents generally received information about their children’s care.

**CQC Children’s survey 2014 – Q28**

In the CQC children’s survey 2014 the trust scored 8.66 out of ten for the question ‘Did a member of staff agree a plan for your child’s care with you?’

This was about the same as other trusts. *(Source: CQC Children’s Survey, RCPCH)*

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff were clear about the process of referring to mental health services and felt appropriately skilled to deal with issues of capacity or issues relating to mental health.
Staff gave an example of an issue that occurred on the children’s ward which was dealt with appropriately by the staff on duty and the nurse in charge.

The service was linked into a learning disability liaison nurse who could provide support to both staff and patients.

The staff were aware of the right children had to be involved in decision making regarding their treatment.

All medical and nursing staff we spoke to understand the Gillick principle which focuses on the competency of children to make informed decisions about the treatment they were receiving.

CQC Children’s Survey Data

The children’s services performed at the England average in all of the questions relating to effective in the CQC children’s survey 2014.

CQC Children’s Survey questions, effective domain, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Did a member of staff agree a plan for your child’s care with you?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.66</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you think the hospital staff did everything they could to help ease your child’s pain?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>7.97</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>E3</td>
<td>0-15 adults</td>
<td>7.78</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>36. Did the members of staff caring for your child work well together?</td>
<td>E4</td>
<td>0-15 adults</td>
<td>8.14</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>E5</td>
<td>0-15 adults</td>
<td>7.51</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24. Did your child like the hospital food provided?</td>
<td>E1</td>
<td>0-7 adults</td>
<td>6.17</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>11. Do you think the hospital staff did everything they could to help your pain?</td>
<td>E1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>4. Did you like the hospital food?</td>
<td>E1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Is the service caring?

Staff provided good care to patients with compassion and also provided emotional support.

Feedback from patients confirmed that staff treated them well and with kindness.

At our last inspection in 2016, a number of staff spoke about the impact staffing numbers had on their ability to care for children and families in the way they would like. The service was seen as requiring improvement.

At this inspection we observed positive interaction from staff in waiting areas and wards towards patients, making them feel at ease.

The staff gave examples of good practice and sometimes went beyond what was expected in giving care.
Every member of staff stated that the service had changed since they were last inspected and although the clinical environment was busy and the actual space was restrictive things had improved.

**Compassionate care**

We found that staff delivered compassionate care to patients in children’s services. The staff told us they now had the resources to deliver time and energy to children since the last inspection.

We found that data collected in the last CQC children’s survey regarding how caring children’s services were was sometimes out of sync with what we found whilst on inspection.

The data showed that caring was adequate and could be improved, whilst the inspection found high standards of care including examples of excellent care highlighted by families.

We saw staff played and interacted with children and although many children were ill we still saw children smiling and laughing with siblings.

A patient described the care given by the children’s ward as “wonderful”, especially by two nursing staff that supported her child. She stated “Nothing was too much trouble and they really cared about the level of care they were providing, they also had so much respect for the parents”.

We spoke with two parents who decided to travel to North Manchester General, rather than access their local children’s hospital. The parents stated “The service provided here (North Manchester) is better, staff look after our child and we think it’s safe and supportive.” The staff are brilliant”.

We found collectively, patients described that the service was friendly, good, hygienic, caring and safe.

Another parent said that “nurses had gone out of their way to look after us”.

We spoke with eight families during the inspection of children’s services in North Manchester General. The families all spoke positively about the care and treatment they received.

Medical staff were also spoken about positively.

We spoke to one family, who had been on a children’s ward for almost a week, they explained that the doctors and nurses were brilliant. Communication was good and doctors were ensuring that they understood what was happening.

Staff felt that excellent progress had been made since the last CQC inspection in 2016. The service had invested in play staff, toys and two visual and tactile rooms for children to play in.

Staff were clear that patients’ privacy and dignity was key in the provision of a good service. However staff felt that the environment could be made even more supportive by increasing the bed space and internal space of units.

We talked to staff who stated they were proud of the service’s performance in the wake of a major incident in Manchester. Staff told us that colleagues rallied together, coming in and reporting for duty without being asked or expecting to be paid.

The NHS Friends and Family test (FFT) is a satisfaction survey that measures patient’s satisfaction with the health care they have received. The trust supplied us with data for paediatric services from July 2015 until September 2017. The score for FFT was approximately 80% for positive satisfaction rates.

Senior managers in the trust were highlighted by paediatric nurses as going beyond what was expected. The Chief Executive and directors undertook walkabouts and visited the A&E department, bereavement services and other ward where children and families had been placed.

Every member of staff we talked to were passionate about patient care and were proud of the service they delivered. Staff talked about prioritising patients before themselves and making a difference in people’s lives, they had a strong commitment to choice regarding treatment and
equality.
Families were impressed with the play areas on wards and in A&E department. The parents felt that the areas reduced stress in their children and made the service more children friendly.
We were present when one child who had been previously disruptive in A&E department had just been admitted to the ward. We could see how the child played with staff and their parent in the cubicle.
The service had two dedicated play specialists who worked on the children’s wards and in A&E department. Parents were impressed with the work carried out by the play specialists who supported all children both patients and siblings.
Staff told us that play staff normalised the environment. On inspection we saw a number children laughing and playing with play specialists.

**CQC Children’s survey 2014**

The trust performed worse than the England average in four out of 14 questions relating to compassionate care in the CQC children’s survey 2014.
The trust scored worse for the following questions:
Q35 - Were members of staff available when you or your child needed attention?
Q10 - Did staff play with your child at all while they were in hospital?
Q40 - Do you feel that the people looking after your child listened to you?
Q41 - Do you feel that the people looking after your child were friendly?

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Overall… (please circle a number)</td>
<td>C1</td>
<td>0-15 adults</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>35. Were members of staff available when you or your child needed attention?</td>
<td>C1</td>
<td>0-15 adults</td>
<td>7.46</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>8. Was your child given enough privacy when receiving care and treatment?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>6. Did you think there were appropriate things for your child to play with on the ward?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>7.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>10. Did staff play with your child at all while they were in hospital?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>5.40</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>11. Did new members of staff treating your child introduce themselves?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40. Do you feel that the people looking after your child listened to you?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>7.70</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>41. Do you feel that the people looking after your child were friendly?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.33</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>42. Do you feel that your child was well looked after by the hospital staff?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.43</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Were you treated with dignity and respect by the people looking after your child?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.72</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Were you given enough privacy when you were receiving care and treatment?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>18. Do you feel that the people looking after you listened to you?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>19. Do you feel that the people looking after you were friendly?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>20. Overall… (please circle a number)</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We found the trust did support parents and patients to be involved in their care.

Patients and carers confirmed this when we spoke to them as a part of the inspection.

The staff were described as being kind, supportive and non-judgmental towards parents and children.

All the patients commented on how regularly staff communicated with them, checking every hour to see how families were coping and introducing themselves when shifts began. Patients described how staff showed them respect and ensured their dignity was maintained.

We found staff demonstrated a good understanding of the needs of the children and their carers.

The staff we spoke with demonstrated a good understanding of people’s personal, cultural, social and religious needs.

We found that the trust performed about the same or better than the England average in 18 of 19 questions in respect of patient and care involvement in the CQC children’s survey conducted in 2014.

It performed about the same as other trusts for 17 out of 19 questions relating to understanding and involvement of patients and those close to them in the CQC children’s survey 2014.

The trust performed better than other trusts for the following question:

Q43 - Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?

The trust performed worse than other trusts for only one question:

Q19 - Were you told different things by different people, which left you feeling confused?

CQC Children’s survey 2014

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Did hospital staff tell you what was going to happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.10</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>27. Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29. Did you have confidence and trust in the members of staff treating your child?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.22</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>30. Were you encouraged to be involved in decisions about your child’s care and treatment?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.91</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.90</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32. Did staff ask if you had any questions</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.49</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
### Emotional support

Staff provided emotional support to patients to minimise their distress.

We found a high level of emotional support provided by staff in children’s services. Staff were able to put themselves into the position of others and therefore offer meaningful support.

Staff were also able to reflect on children’s needs particularly in terms of vulnerability and being away from home in unfamiliar circumstances. The staff were fully aware of the impact of a child’s illness on children, parents and carers.

We received feedback from parents one of whom described the care given by the children’s...
ward. The patient described “the wonderful care and attention” provided by staff especially by two nursing staff who cared for her child. “Nothing was too much trouble and they really cared about the level of care they were providing, they also had so much respect for parents.

We were told a nurse went to see a child on another ward after encountering the patient the night previously. The child had been disturbed and had threatened to hurt themselves when they were taken into the hospital the night before. The nurse sat with the child and ate toast and drank tea with them before the start of her new shift on another ward.

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for the questions relating to emotional support in the CQC children’s survey 2014.

**CQC Children’s Survey questions, emotional support, The Pennine Acute Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did a member of staff tell you what to do or who to talk to if you were worried about your child when you got home?</td>
<td>C3</td>
<td>0-7 Adults</td>
<td>8.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>7. If you had any worries, did someone at the hospital talk with you about them?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>15. Did hospital staff tell you what to do or who to talk to if you were worried about anything when you got home?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

**Is the service responsive?**

The trust planned and provided services in a way that met the needs of local people.

We found that the trust reviewed data regarding its local population and took this into account when developing services.

Data showed that services were responsive to local communities and their needs.

Data we received showed that parents were on the whole positive about the trust’s responsiveness rates. The service was seen as providing a responsive service which was similar to other trusts in terms of facilities and flexibility of admission. In our inspection parents spoke highly of staff who were deemed as supportive and responsive to parents requests.

We found a number of information leaflets available in different areas which guided parents and carers to services.

People could access the service when they needed it.

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for all of the questions relating to responsiveness in the CQC children’s survey 2014.

**CQC Children’s Survey questions, responsive domain, The Pennine Acute Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
</table>
37. Did you have access to hot drinks facilities in the hospital?  

<table>
<thead>
<tr>
<th></th>
<th>0-15 Adults</th>
<th>15+ Adults</th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>8.58</td>
<td>7.56</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

39. How would you rate the facilities for parents or carers staying overnight?  

<table>
<thead>
<tr>
<th></th>
<th>0-15 Adults</th>
<th>15+ Adults</th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>8.58</td>
<td>7.56</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

2. Did the hospital give you a choice of admission dates?  

<table>
<thead>
<tr>
<th></th>
<th>0-7 Adults</th>
<th>NA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>0-7 Adults</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

3. Did the hospital change your child’s admission date at all?  

<table>
<thead>
<tr>
<th></th>
<th>0-7 Adults</th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>R3</td>
<td>9.12</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Key:  
- Better than other trusts  
- About the same as other trusts  
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

The trust has set up a number of Patient Participation Groups (PPG) which provided an opportunity for local commissioners, providers and members of the public to work together for the benefit of the local area.

The trust set up a Children and Young people’s Group (C&YPEG) where children and young people were consulted in the development of paediatric services.

In April and June 2016 local children reviewed paediatric areas at North Manchester General Hospital. The children shared their findings and recommendations with members of the Trust Board.

The trust have set up an ongoing programmes of engagement with the group in co-producing a number of initiatives including a children’s and young person’s engagement strategy, a children’s and young person’s forum and also children’s participation in the recruitment of staff.

Meeting people’s individual needs

The service took account of patients’ individual needs. The trust developed a tool kit to improve the care and experiences of young people with learning difficulties. The learning disability lead nurse and paediatric speech therapist have led on the development and introduction of a care pathway for young people with learning difficulties.

Children with a learning disability and/or autism were highlighted by a flagging system at admission on to wards. The system was used to inform the learning disability nurse of the patient’s admission.

This process enabled the learning disability nurse to contact the ward and any community services that the patient was known to, to establish any reasonable adjustments that needed to be put in place after admission. This includes any specific needs related to care planning including epilepsy.

Children’s services had access to an alcohol referral service for young people. The service supported patients under 19 who had consumed alcohol and attended hospital intoxicated or had alcohol as a contributing factor in their attendance.

Patients were assessed and referred in to treatment if and when required. The service also supported patients whose alcohol use had made them safeguarding risks and this process was supported by the trust’s safeguarding team.

The trust was implementing its mandatory duty to the NHS England Accessible Information Standard for young people. The standard applies to all health and adult social care organisations.

The standard states that the trust has a duty to support access to their services by patients who may have an information and/or communication need, such as blind or deaf patients. The duty also includes making sure that people get information in different formats if they need it, such as large print, braille, embossed, easy read, via email and or visual/British Sign Language (BSL).

An example of how the service was implementing the standard included a communication and information needs passport’ for patients, service users, carers and parents. The passport was launched at an accessible information standard launch event held at North Manchester General
Hospital in September 2016.

The passport supports health and social care staff to identify the communication and information needs of patients and service users who have a disability, impairment or sensory loss. The passport enables patients and carers to access and understand the information that they are given.

The trust had its own interpretation and sign language service. The sign language service was used for patients with sensory difficulties and braille or large text documents provided for visually impaired patients.

The trust provided a Spiritual Care Team which met the emotional, spiritual or religious needs of any children or carers who needed support. The service was available, 24 hours every day, 365 days a year.

The service provided access to the three main religious groups in the foot print of North Manchester General i.e. Church of England, Roman Catholic, Jewish and Muslim chaplains. The service also has approximately 60 volunteers from various faith groups (including one humanist) who visited most wards weekly.

The hospital worked with the Jewish and Muslim communities in North Manchester to provide a bespoke end of life service for children who were end of life patients. Religious resource boxes were available on all wards including material accessed for end of life. The boxes provided immediate access to scriptures, prayers and artefacts for the main faiths. The hospital also provides access to Baby Memorial Services in July of every year. Additional support was given to Jewish patients and families through Ezra Care (formerly Ezra Umarpeh) Ezra provide kosher food and other Jewish materials in the hospital.

The trust was in the process of ratifying a Transgender Policy. The policy covered the needs of transgender patients and the wider area of transgender issues as well as gender reassignment.

To support the policy, staff were encouraged in accessing sexual orientation and gender identity training. The trust also provided bespoke access to disability awareness training and deaf awareness training.

Access and flow

The children’s services in North Manchester developed a patient flow coordinator post which allowed the trust to take an overview of patient numbers on a daily and weekly basis. Staff and senior managers felt the post was integral to assuring there was decreased risk of bed blockages on wards. We were told that the coordinator supported the implementation of safe staffing on wards.

Nurse leads and staff would meet every day before shifts started to review patient numbers and the number of staff required to manage those numbers. The management of the children’s service would also receive an update every 4-5 hours on the occupancy rate.

The hospital had developed a paediatric escalation plan, which they provided us with a copy. The plan clearly set out the actions staff needed against bed blockages. The plan included a traffic light process from a point of no action to a point where unit managers considered closing services.

Data we received showed that most children stayed on a designated children’s ward. The children’s service was at the England average when compared to other services.

In the CQC children’s survey 2014 the trust scored 9.77 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’

The measure is if children spent most of their time on a children’s ward rather than an adult ward. This was about the same as other trusts. (Source: CQC Children’s Survey, RCPCH)
Between May 2016 and April 2017, the trust has seen neonatal bed occupancy fluctuate slightly month on month, with March and April 2017 seeing the highest occupancy levels throughout the period.

Occupancy levels were lower than the England average for eight months of the period and higher than the England average for March and April 2017.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. *(Source: NHS England)*

### Learning from complaints and concerns

We found the children service had a low number of complaints. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

A trust wide complaints policy existed in the trust which directed patients to the Patient Advice and Liaison Service (PALS). The policy included information on how patients or carers could raise concerns, make their complaints and share compliments.

The complaints process as well as compliments could be accessed through the trust's website as well as through wards.

Clinical and medical staff we interviewed in North Manchester children's services were aware of the complaints procedure and told us information about complaints was discussed as they came up.

Complaints were logged by PALS and patients or carers were regularly updated on the complaint and a formal record kept.

The complaint log was submitted centrally to the trust for review and discussion.

We were told by staff that they tried to deal with complaints informally, in an attempt to come to a satisfactory conclusion for the patient. If this was not resolved locally, the complaint was escalated for further investigation.

### Summary of complaints

Between June 2016 and May 2017 there were 22 complaints about Children and Young People’s services (2.7% of all complaints).

The trust took an average of 68 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 13 complaints still open and yet to be completed.

There were 11 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 50%.
North Manchester General Hospital: There were 9 complaints (40.9%)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The complaints we were provided with had no obvious pattern regarding type of complaint and did not centre on one particular department.

The service had 5 compliments in the period 1 June 2016 to 31 May 2017.

**Is the service well-led?**

**Leadership**

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

In our last inspection we found significant concern about how well led the service was. However, in this inspection staff felt that managers and professional leads were supportive and informative, particularly at ward levels.

The staff felt proud of their services and despite changes in leadership models felt positive about the organisation and their role in it.

We found that issues which were present in our last inspection such as the lack of medical cover, nursing cover and staff engagement were being tackled and the staff were appreciative of the response.

Staff told us they felt listened to and there was an awareness of the journey staff had taken since our last inspection.

We found no complaints about leadership from both medical and nursing staff. Managers in children’s services were seen as supportive.

We found visible leaders on wards and across directorates and the service’s structure had taken into account the differing needs of all four areas of the children services.

The directorate leads were supported by matrons and band 7 team leads who told us that they had good communication between wards and the trust leadership.

All staff understood who to report to and were able to identify managers up to directorate level and beyond.

The staff told us that they were aware of leadership visits to wards and directorates as part of a trust initiative to support staff in the changes that were occurring in North Manchester.

**Vision and Strategy**

The values of the trust were displayed in areas throughout the service.

Pennie Acute NHS Trust was presently going through a number of structural changes in the way it functioned and was moving into a care organisation model.

We found the hospital was in a period of transition at the time of inspection. The paediatric staff had been involved in this process and the department was engaging with its counterparts in Salford in preparation for transition.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
Managers that we met and interviewed were positive about the service and had a “can do”, approach to implementing change. Managers told us they were seeing change since the last inspection.

We found managers and staff to be open and transparent. Staff were proud to show off their respective work and teams and wanted to talk to us about the care they provided to patients.

A previous serious incident in the city centre had brought staff teams together and staff spoke respectfully of the director team and how they had approached dealing with the incident and after math.

Staff not only supported patients but also other colleagues. We were present when a serious medical incident occurred in A&E which obviously distressed all the staff involved. Whilst the staff showed real professionalism it was also clear that the incident had a real impact on them as a collective group. Medical and nursing staff rallied around each other providing emotional support as well as professional guidance. We also saw how staff reflected on the family involved.

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The staff we spoke with demonstrated strong commitment to the hospital and the local population.

Clinical leads were proud of the changes they had made in gaining extra clinical posts and had positive relationships with junior doctors.

**Governance**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was a review of all cases provided at the mortality and morbidity meetings. There was a focus on learning lessons with wide ranging attendance from across the division.

Staff worked together on governance issues. A series of directorate meetings were in place across children services which included input from medical staff, clinical staff and senior managers.

Governance arrangements were well embedded. The service had a monthly governance meeting, weekly management meetings including incident reporting and performance meetings on a two week basis.

Staff felt that services were safe and that arrangements were clear.

Data was available which allowed services to monitor performance and highlight risk or concerns through a trust wide electronic system.

Audits were undertaken by senior managers and the findings were shared across the service.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were local and trust wide risk registers that identified risk across the paediatric and neonatal departments.

Risks were identified on registers and controls were put in place. Managers gave assurances with mitigating actions. The trust had concentrated its effort in decreasing the risks associated with potential lack of medical and nursing staffing in paediatrics and neonatal by trying to recruit to new posts.

The register clearly identified that clinical staffing posts, particularly nurse staffing had been
challenging to recruit to.

We found that managers from ward to directorate level were clear about their roles and there was evidence that quality and risk were managed appropriately through written team meeting minutes, huddles and individual face to face discussion.

The hospital had developed a new children’s service dashboard which was provided to us. The dashboard identified safety incidents, admissions and re-admissions data as well as training and patient feedback.

When we asked staff, most were able to identify the issues which had arisen from our previous inspection in 2016.

Staff felt that managers had passed on concerns that arose and staff were able to identify positive actions that had arisen. The issue regarding medical staffing was a clear example.

The advent of a patient flow coordinator was part of a management response to bed blockages and waiting times across children’s services.

The role had made some impact on access and flow in services and information on waiting times and other performance data was available and reviewed on a daily basis with managers.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

On 15th November 2016, the Trust held a multi-faith focus group meeting involving members of the public and representatives from local communities and various religious groups to consult and discuss on how the trust could improve its End of Life (EoL) services for patients and families.

The trust has participated and set up a Healthier Together programme. The programme looks at collective ways patients and health professionals can improve services. The programme was set up to reflect, where possible, the local population and ensure that those equality groups who are disproportionately affected by the proposals have the opportunity to be involved.

The trust set up a Children and Young people’s Group where children and young people were consulted in the development of paediatric services. Young people shared recommendations on the shape of services and sat on interview panels.

Children’s services participated in the Friends & Family test which showed 86% approval ratings for North Manchester children’s services from August 2016 to July 2017.

**Learning, continuous improvement and innovation**

The trust supported a programme of work which was developed to support transition of paediatric services into and transfer of services to Central Manchester Foundation Trust. The work involved active engagement between the care organisation’s staff to prepare for change and understand upcoming challenges.

The trust’s Paediatric clinical team at North Manchester was shortlisted as finalists in this year’s British Medical Journal (BMJ) Awards in London in the Prevention category. Despite not winning, the team were highly commended for their work on flu vaccine for children. Last year they implemented a new innovative public health initiative in the fight against flu.
The Royal Oldham Hospital

Urgent and emergency care

Facts and data about this service

Urgent and emergency services are provided at The Royal Oldham Hospital to adults and children primarily in the Oldham area of Greater Manchester, and compliment the urgent and emergency services provided in the region by Pennine Acute Hospitals NHS Trust at North Manchester General Hospital and Fairfield General Hospital.

Services are provided at Oldham 24 hours a day seven days a week. Between October 2016 and September 2017, there were 103630 accident and emergency department attendances across the trust. This equates to an average of 284 patients a day.

Urgent and emergency services are provided for adults and children. The department had an orthopaedic trauma unit. The hospital also had a children’s ward and a children’s observation and assessment area.

The department has five adult resuscitation bays, one trauma treatment room, and one resuscitation bay specially equipped for children. There are ten curtained cubicles and two treatment rooms for patients with major injuries and eight curtained cubicles and one treatment room for patients with minor illnesses.

The department has separate waiting and treatment rooms for the use of patients in the custody of police or prison staff, and for patients presenting with mental health symptoms.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them.

Urgent and emergency services at this hospital were last inspected in 2016. At the last inspection, we rated two or more key questions as requires improvement so we re-inspected all five key questions.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited the accident and emergency department at ROH between 18 October and 19 October 2017. We inspected the whole core service and looked at all five key questions. We spoke to five patients and carers and 45 staff from different disciplines, including support staff, nurses, doctors, managers and senior managers, support staff and ambulance staff. We observed daily practice and viewed 18 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Is the service safe?
Mandatory training

The service provided mandatory training in key skills to all staff.

Staff underwent a mixture of statutory core and essential job specific related training. Statutory training included a range of subjects as set out in the table below. Training was delivered through a mix of classroom and online training. The trust set a target of 90% completion of mandatory training for each business year from April to March. By the time of the inspection training rates for nursing staff were better than target at 95%. However, 81% of medical staff had completed core mandatory training which was below the trust's target.

Mandatory training completion rates

The trust set a target of 90% completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in Urgent and Emergency Care are shown below:

Medical and dental staff working in Urgent and Emergency Care failed to meet the 90% target for mandatory compliance for all 16 modules.

Paediatric basic life support and basic life support training had the lowest compliance levels with only 37% and 51% of eligible medical and dental staff having been trained.
Nursing and midwifery staff working in Urgent and Emergency Care met the 90% target for mandatory training compliance in three modules (equality and human rights tier 2, hand hygiene assessment and information governance).

Immediate life support and paediatric immediate life support training had the lowest compliance levels with only 33% and 48% of eligible nursing and midwifery staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Data provided at the time of the inspection reflected the number of eligible staff for each module and demonstrated that 95% of staff had completed basic life support and 91% had completed basic paediatric life support; 79% had completed advanced life support, 100% had completed advance paediatric life support; 55% had completed immediate life support and 57% had completed immediate paediatric life support.

The divisional director and practice educator both acknowledged that complete rates for immediate life support were low; however, this was due to a recent change in trust policy from a two year to a one year renewal cycle. Future dates in February 2018 were available to provide training to remaining staff.

Safeguarding

Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so. Safeguarding training on how to recognise and report abuse was included in the trust’s mandatory training schedule. However, there was an inconsistency in knowledge of how to use the service’s policies in safeguarding children and young people. However, we did not see any evidence to indicate that staff had missed or failed to identify safeguarding issues in any specific cases.

Staff we spoke with were able to describe the types of indicators of abuse or neglect that would lead them to consider reporting a safeguarding concern. Staff were aware of the need to be vigilant and assess for indicators of child sexual exploitation, female genital mutilation and domestic violence. Masterclasses had been delivered by the trust’s safeguarding teams which included issues related to female genital mutilation, male circumcision, and domestic abuse.

Training was also provided in the government’s counter-terrorism Prevent Strategy, and referrals for this were managed through the multi-agency safeguarding hub. One hundred per cent of eligible nursing staff had received this training.
Staff were aware of how to find contact details of the trust’s safeguarding team, which were available Monday to Friday between 8am and 6pm, or the local authority’s safeguarding teams where they could obtain further advice if needed.

Safeguarding referrals were completed electronically for review by the trust’s safeguarding team before transfer to the relevant local authorities. Staff used the information sharing form to alert relevant people to any high risk patients who needed safeguarding. A list of options on the form aided staff to decide who the alert went to; these included the health visitor, school nurse, social services. If a child was in immediate danger staff completed a section 47 referral for immediate action to be taken by social services. We observed this had been done, and an alert sent to social services, for one patient in the department.

The electronic patient record system flagged up any previous known safeguarding concerns or referrals on the patient’s records. This meant that staff were able to identify patients who were previously considered potentially to be at risk.

Children who were 16 or 17 years old were treated as adults in the department in line with trust policy and flowchart for wards admitting children aged 16 to 18 to adult wards. Where children needed to be admitted they were offered the choice of admission to the children’s ward or to an adult ward. However, this limited the opportunities for staff to identify and meet their safeguarding needs as children. We were told that concerns relating to the management and treatment of these children was shared by the safeguarding team and was a current agenda item for each of the four local safeguarding children’s boards.

Children and young people were not consistently assessed in the department using the paediatric assessment form. The pro-forma, which was different to those used in the trust’s other urgent and emergency services, lacked some key safeguarding prompts. This meant there was some reliance on individual practitioners’ professional curiosity, which limited the opportunity to consider the ‘think family’ approach or for the early identification of safeguarding issues. Adults attending the department were not routinely asked at triage if they had regular contact with children, nor did practitioners working with adults adequately consider if children could be affected by adults physical or mental ill-health. However, the lead nurse appeared keen to identify ways that this could be addressed.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in Urgent and Emergency Care is show below:

NB – data from the following teams have been used for the below as the trust didn’t include a specific Urgent and Emergency Care core service for the training data supplied in the RPIR:

BD215 - Medical Staff - UCC (Rochdale), BD311 - Urgent Care Centre (Rochdale), BE404 - Urgent Care Teams, CB100 - Urgent Care Mgmt (Bury), CB101 - Urgent Care Mgmt (North), CB102 - Urgent Care Mgmt (Oldham), (Oldham), CB205 - Medical Staff - A&E (Bury), CB210 - Medical Staff A&E (North), CB225 - Medical Staff - A&E (Oldham), CB305 - Accident & Emergency (Bury), CB307 - Accident & Emergency (North), CB309 - Accident & Emergency (Oldham), CB322 - A&E - ENPs (North), CB324 - A&E - ENPs (Oldham), CSPR - Accident and Emergency (SPRs)
Medical and dental staff working in Urgent and Emergency Care at the trust didn’t meet the 90% target for any of the safeguarding modules. Level 2 adults and children both had 85% compliance with 74 of the 87 eligible staff members completing the training in both these modules.

Compliance for level 3 adults was the lowest, with only 44% of required staff members completing the training.

Data that the trust provided at the time of the inspection demonstrated that 92% of medical staff had completed adult safeguarding level two training and 90% of medical staff had completed children safeguarding level two training. This was against the trust’s target of 90% for years 2017 to 2018.

Nursing and midwifery staff working in Urgent and Emergency Care at the trust exceeded the 90% completion target for both level 2 adults and children Safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Data provided at the time of the inspection demonstrated that 100% of nursing staff had completed safeguarding adults level two training and safeguarding children level two training. Ninety per cent
of eligible staff had completed safeguarding adults level three training, and 100% of eligible nursing staff had completed safeguarding children level three training. At least one level three trained staff member was assigned to each shift. It was intended that level three children’s training would be extended to all band five nurses working with children across the trust. This was awaiting a decision from the trust board.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection.

The department and equipment used within it were visibly clean and tidy during our visit. Domestic cleaning services, provided by an external company, undertook the environmental cleaning in each bay while nurses cleaned the trolleys and equipment. The cleaning logs were checked by the provider’s supervisor up to twice per week and audited by the provider’s quality team every three weeks. We viewed the cleaning logs which were up to date and completed appropriately.

There were sufficient numbers of antibacterial hand gel dispensers located throughout the department and we observed staff using these.

A laminated ‘simple steps to making patients safe’ leaflet was provided at every bedside on the observation ward. This included information on infection control, including effective handwashing.

We observed staff following accepted infection control and hygiene procedures, including washing hands and having ‘arms bare below the elbow’. There were sufficient quantities of personal protective equipment such as gloves and aprons throughout the department and within each bay. We observed staff using protective equipment appropriately.

In the 12 months prior to the inspection, the department had reported no cases of methicillin resistant staphylococcus aureus or clostridium difficile.

**Environment and equipment**

The service had suitable premises and equipment.

The main reception desk was situated at the entrance of the adult waiting area. The adult waiting room was visibly clean and tidy, and included a range of toys. The reception desk continued into the paediatric waiting area where it was designed to resemble a bus. This enabled line of sight for reception staff into the paediatric waiting area. Toys were available in the waiting area.

The entrance into the paediatric waiting area could be secured by a secure call bell system, which remotely operated from the reception. This was used at night and at weekends, which meant that access to the area was restricted. The waiting area, toilets and a baby changing facility were visibly clean during our visit. However, parents and carers expressed contrary views of this comment on cleanliness of the waiting area and toys in it, with some commenting the area was cramped with nowhere for parents to sit. Most of the parents and carers we spoke with said the waiting area was too hot.

There were five cubicles within the paediatric area. Staff were concerned this was not sufficient to meet the rising demand of the department. This was of particular concern when the department experienced delays in transferring children to the children’s ward or in assessment by the children and adolescent mental health services. This was on the department’s risk register.

The adult waiting area was visibly clean and included adequate seating. Male and female toilets were available and were clean. Well-stocked vending machines provided access to drinks and snacks, and a range of leaflets were available. Signage throughout the department, and on the floor, was clear and helped patients and carers to find the areas they needed to attend.

The adults ‘majors’ and ‘minors’ illnesses areas were laid out to provide line of sight for all bays and cubicles from the nurses stations. Patients brought in by ambulance were triaged in a cubicle
in the majors area. Staff told us plans were being developed to increase the capacity of the ambulance triage area to accommodate three trolleys at the same time. The department was co-located to the x-ray area.

The service had an eight-bedded observation ward for patients that required additional observation before a decision to discharge was made; for example, patients with low risk chest pain, head injury, or allergic reaction. The ward was physically separated into two rooms with the nurses’ station in the middle, which prevented breaches in the single sex accommodation requirements.

A memory room was located next to the observation ward, and could be used by patients to eat their meals. The room had been designed with photographs from different eras for the support of patients living with dementia. A memory box and support leaflets were available in the room.

The Swan Suite consisted of a relatives’ room and viewing room. This enabled families and carers to spend time with their deceased relatives in a quiet and appropriate setting. The adjoining door between the rooms meant that relatives’ dignity and privacy could be respected.

Resuscitation trolleys were located in the paediatric, majors, and resuscitation areas. All trolleys were appropriately sealed and tagged. An easy guide, incorporating photographs of each drawer on the trolley assisted staff to ensure the right equipment was in place. We checked a random sample of the trolleys and equipment within them. Equipment was within the manufacturers recommended expiry dates. Daily checks had been carried out appropriately and these were recorded in the log.

Portable electrical equipment throughout the department was tested and maintained. We reviewed a range of equipment in all areas of the department and found only one piece of equipment, baby weighing scales, which had passed the recommended testing date.

The urgent and emergency department had a designated mental health assessment room. The room offered privacy for the assessment of patients with suspected or actual mental health needs. The room was appropriately designed and had two doors to ensure staff had an appropriate means to leave the room. The room had a strip alarm on all walls so that staff and patients could summon assistance if needed. The room did not contain any ligature points. For example, places to which a cord, rope or other material could be attached for the purposes of hanging or strangulation.

There was no designated safe room for children experiencing mental health symptoms who were higher risk in the department. These children were cared for in one of the cubicles within the department. Staff reported this did not cause major problems but that they had at times used security to assist them when older children were displaying aggressive behaviour. When asked how they would manage if a patient was a threat to other young children staff reported they would use their high dependency room, which could be stripped of cords and wires. Staff, or a family member, stayed in the room with the patient. In the event of an emergency situation the police would be called.

There was a health-based place of safety on the hospital site which was managed by the local mental health NHS trust. This was used by the police to bring people in from public places for an assessment under section 136 of the Mental Health Act. Police would usually only bring people to the emergency department on a section 136 if they also required medical attention.

**Assessing and responding to patient risk**

The urgent and emergency department had a process in place for triaging walk-in patients. Nurse-led initial assessment and triage enabled streaming of patients to the most appropriate area to be seen and to fast-track relevant patients for pre-emptive investigations. This enabled early identification of patients at risk of developing sepsis, patients with head injuries or other trauma related injuries. Assessment of patients arriving by ambulance was aided by the use of a situation, background, assessment and recommendation tool.
Patients suitable to be seen by a GP were triaged to the GP streaming service which operated between 11am and 11pm seven days a week. Patients suitable to be seen and treated by an emergency nurse practitioner were identified at triage.

The department had a sepsis lead and sepsis champion in place. Patients suspected of having neutropenic sepsis (a life threatening complication of anticancer treatment) were given a purple card at reception and immediately triaged and fast-tracked for appropriate care. Patients who were suspected of having infection were identified with an orange wristband. Early identification of patients at risk of sepsis meant staff could implement the sepsis six pathway and tool kit. Patients classified as at ‘red’ risk had vital observations carried out at 15 minute intervals; those at ‘amber’ risk had observations carried every 30 minutes; and those assessed as ‘green’ had observations every hour.

The department used a national early warning score system in conjunction with the department escalation plan to ensure that deteriorating patients were appropriately escalated to medical staff. The Manchester children’s hospital early warning system was used in the paediatric department. Staff used age-appropriate observations including oxygen saturation levels, heart rate, and consciousness levels.

Patients presenting with chest pain were given a red card at reception and brought straight to a cubicle in the major’s area for assessment and an electrocardiogram trace. Patients with head injuries or allergies were identified by the use of other coloured cards.

Risk assessments for pressure ulcer and falls assessments were carried out. The skin bundle was implemented for any patients at risk of developing a pressure ulcer, which included the provision of pressure relieving mattresses for patients in the department longer than four hours.

Patients at risk of falls were identified by the use of a golden leaf symbol. Patients living with dementia were identified by the use of the forget me knot symbol.

We saw evidence in the records that staff had assessed and documented patients’ pain scores, early warning scores, falls risk and pressure ulcer risk. We reviewed eighteen sets of records, which indicated that pain relief was prescribed and administered in a timely way in six cases where it was required. However, one record indicated that pain relief was administered four hours late. In three cases where antibiotics were required these were prescribed and administered in a timely manner.

Only doctors or consultants were able to agree and sign-off patients for discharge from the department.

Patients presenting with mental illness were referred to the specialist mental health liaison staff called the rapid assessment, interface, and discharge team, which was also supported by the on-site police liaison officer. Staff in the emergency department could refer directly to the team. The team had access to the department’s computer systems. The team recognised that referrals to the children and adolescent mental health services could be delayed if made after 4pm and that on occasions this may require a child to be admitted to the children’s ward to ensure their safety while awaiting assessment.

We observed staff responding quickly and efficiently to an emergency call within the department, and the dignity of the patient was maintained throughout.

A dedicated trauma consultant was based in the department between 8am and 8pm, with overnight cover provided by a trauma registrar. The ambulance service pre-alerted the department for all patients that were suspected of sustaining a trauma injury. Patients were screened and assessed on arrival using a trauma assessment sheet that had been developed in the department with appropriate patients sent for full body CT scan. Scan and x-ray results were reviewed appropriately and trauma pathway documentation was printed automatically from the department’s computer system for any patients admitted to the orthopaedic ward.

The trust scored “about the same” as other trusts for all five of the 2014 survey questions relevant to safety.
**Question** | **Score** | **RAG**
---|---|---
Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&E staff? | 8.6 | About the same as other trusts
Q6. How long did you wait before you first spoke to a nurse or doctor? | 7.0 | About the same as other trusts
Q7. From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse? | 7.0 | About the same as other trusts
Q31. In your opinion, how clean was the A&E Department? | 8.5 | About the same as other trusts
Q32. While you were in the A&E Department, did you feel threatened by other patients or visitors? | 9.4 | About the same as other trusts

(Source: CQC - A&E Survey (01/01/2014 - 31/03/2014)

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

The trust did not meet the standard for 12 months over the 13 month period between August 2016 and July 2017.

Performance improved from May 2017 onwards where performance was closer to the standard than in previous months during the period.

In July 2017 the median time to treatment was 65 minutes compared to the England average of 60 minutes.

**Time to treatment all patients between August 2016 and July 2017 at The Pennine Acute Hospitals NHS Trust**

![Graph showing median time to treatment](image)

(Source: NHS DIGITAL: A&E quality indicators)

For Oldham, between October 2016 and September 2017, the median time from arrival to treatment for all patients varied from a maximum of 89 minutes in the winter period of February 2017 and a minimum of 59 minutes at the beginning of the summer period in May 2017. In September 2017, the median time from arrival to treatment was 71 minutes. In all but one month (May 2017) the hospital performed worse than the national median time of 60 minutes.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median for 11 of the 12 months between August 2016 and July 2017.

In July 2017 the median time to initial assessment was 8 minutes compared to the England average of 7 minutes.
Between October 2016 and September 2017, the median time from arrival to initial assessment for emergency ambulances cases at Oldham was also eight minutes. This was in line with the Royal College of Emergency Medicine guidance on the initial assessment of emergency patients.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

The Royal Oldham Hospital

Between September 2016 and August 2017 there was a relatively stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at The Royal Oldham Hospital. With the exception of February 2017 where there was a slightly higher proportion of ambulance journeys with a turnaround time over 30 minutes.

January and February 2017 saw the highest number of turnaround times over 60 minutes throughout the period.

Ambulance: Number of journeys with turnaround times over 30 minutes - The Royal Oldham Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - The Royal Oldham Hospital

The urgent and emergency service collected data on a separate measure of handover times greater than thirty minutes. This was measured from the time of arrival of the patient by ambulance to the service’s acceptance of responsibility for the patient. Between October 2016 and September 2017, Oldham recorded a total of 6455 ambulance arrivals with handover greater than 30 minutes or where no timestamp had been recorded. This equated to an average of 21%
of ambulance arrivals and 538 cases per month.

We spoke with an ambulance crew during the inspection. The crew told us handover was “better at this accident and emergency” and that triage in the department was efficient.

The department had recently supported the introduction of an ambulance liaison officer. The officer’s role was to encourage collaborative working between ambulance and hospital staff, and at times of pressure to coordinate and support ambulance crews awaiting handover. This included ‘cohorting’ patients that had been triaged and were awaiting transfer to a cubicle. This enabled some crews to be released from the hospital, to reduce the handover time, and to improve patient flow.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

Between 06 June 2016 and 29 May 2017 the trust reported 2890 “black breaches”. The number of black breaches increased from December 2016 to January 2017 where it peaked at 509 breaches. The number of breaches has fallen since January 2017, aside from April 2017 where numbers increased again slightly.

![Black breaches per month](image)

*(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)*

Between October 2016 and September 2017, Oldham had a total of 1615 black breaches which equated to an overall average of 135 per month. The number of black breaches peaked during the winter period with 271 breaches in January 2017 and 293 breaches in February 2017, which was in line with the trend for black breaches across the trust.

**Nursing staffing**

The service had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

During our inspection, the urgent and emergency services department had sufficient staff available to fulfil the requirements of each shift. A staffing tool was used to determine staffing levels in line with patient acuity and trust staffing policy.

The department had 12 registered nurses supported by five healthcare assistants within the adult areas per shift. The paediatric department had two registered nurses supported by one healthcare assistant per shift. The observation ward, which only used experienced staff, was staffed with one
registered nurse and one healthcare assistant per shift supported by one supernumerary ward manager.

However, the service leaders recognised that staffing was an ongoing challenge and, as such, continued to look to recruit staff. This included recruiting staff from India who had at least one year’s experience. Twelve new nursing staff had started in the department in September 2017 and were undertaking their induction at the time of the inspection.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in Urgent and Emergency care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>250.83</td>
<td>276.24</td>
</tr>
<tr>
<td>January 17</td>
<td>257.39</td>
<td>276.24</td>
</tr>
<tr>
<td>February 17</td>
<td>258.46</td>
<td>276.24</td>
</tr>
<tr>
<td>March 17</td>
<td>269.46</td>
<td>275.24</td>
</tr>
<tr>
<td>April 17</td>
<td>269.60</td>
<td>275.24</td>
</tr>
<tr>
<td>May 17</td>
<td>272.27</td>
<td>283.86</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 6.8% for nursing and midwifery staff in urgent and emergency care;

- Royal Oldham Hospital: 5%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The urgent and emergency department at Oldham reported it was over established by 8.9 whole time equivalent nursing and midwifery registered staff in September 2017 with 13.2 vacancies in other clinical services. In October 2017, the number of vacancies remained the same, while the number of nursing and midwifery staff remained over-established but at a lower rate of 6.8 whole time equivalent.

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing and midwifery staff in urgent and emergency care;

- Royal Oldham Hospital: 1.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.2% for nursing and midwifery staff in urgent and emergency care, which is higher than the trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 4.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Sickness rates for September 2017 were 1.9% for nursing staff and 4.6% for healthcare assistant staff. This was in line with the trust’s target.
Between June 2016 and May 2017, the trust reported that 50 (approximately 0.1%) qualified nursing shifts in the department were filled by bank staff. This equated to an average of 4.2 shifts per month. In the same period 1380 (approximately 19%) shifts were filled by agency staff, which equated to approximately 115 shifts per month.

For healthcare assistant staff, 830 shifts (average of 70 per month, approximately 2%) were filled by bank staff, while 258 shifts (average of 21 per month, approximately 9%) were filled by agency staff.

The department only used NHS Professionals or existing staff on overtime to cover shifts.

**Medical staffing**

Data provided at the time of the inspection demonstrated the service had 9.75 whole time equivalent consultants in post providing 14 hour cover between 8am and 4pm and on-call cover until 10pm on weekdays. Consultants were supported by an ST4 (specialist trainee year 4) doctor overnight, with an ST3 (specialist trainee year 3) doctor until 3am.

At weekends on-call consultant cover was provided between 9am and 6pm supported by an ST4 doctor 24 hours, and an ST3 doctor.

The service was actively recruiting to consultant posts and it expected to have 12 whole time equivalent consultant staff in post in the next 12 months, rising to 16 staff in total. The aim was to provide 8am to 12pm consultant cover seven days a week.

The department was over-established by three whole time equivalent middle-grade doctors. The middle grade and foundation year junior doctors covered a variety of shifts within the department providing full rota cover. The rota had been ‘heat map’ reviewed three months prior to the inspection to ensure there were sufficient medical staff to cover expected busy periods.

The trust has reported the following planned and actual staffing figures for medical and dental staff working in urgent and emergency care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Urgent and emergency care</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>75.54</td>
<td>104.10</td>
<td></td>
</tr>
<tr>
<td>January 17</td>
<td>76.54</td>
<td>104.10</td>
<td></td>
</tr>
<tr>
<td>February 17</td>
<td>75.04</td>
<td>104.10</td>
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<tr>
<td>March 17</td>
<td>75.96</td>
<td>104.10</td>
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</tr>
<tr>
<td>April 17</td>
<td>77.56</td>
<td>104.10</td>
<td></td>
</tr>
<tr>
<td>May 17</td>
<td>77.56</td>
<td>104.10</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 26% for medical and dental staff in urgent and emergency care;

- Royal Oldham Hospital: -6% (overestablished)

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The urgent and emergency department at Oldham reported 3.2 whole time equivalent medical staff vacancies in September 2017. This increased to 3.9 whole time equivalent by October 2017.
**Turnover rates**

Between June 2016 and May 2017 the trust reported an average turnover rate of 3.5% for medical staff in urgent and emergency care;

- Royal Oldham Hospital: 4.4%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The Oldham department had no medical staff turnover for both September and October 2017.

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 1.5% for medical staff in urgent and emergency care which is better than the overall trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 0%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

In September 2017, the department at Oldham reported a 0.4% sickness rate. We do not have the rate for October 2017.

Between 1 May 2017 and 31 October 2017, 338 medical shifts were covered by internal bank doctors. In the same period, this included 52 medical shifts were covered by agency doctors. Leaders told us that agency locum use was reducing as a result of increasing use of the trust’s bank doctors.

**Staffing skill mix**

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 84 whole time equivalent staff working in Urgent and Emergency Care at The Pennine Acute Hospitals NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>Junior</td>
<td>31%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)
Records

Staff kept appropriate records of patients’ care and treatment. The urgent and emergency service used both electronic and paper records. Contemporary patient paper records were stored in drawers, which maintained security and confidentiality.

Paper records were subsequently scanned onto the electronic system, while the hard copy was retained for six months. Discharge letters were sent electronically through the system to each patient’s GP within 24 hours of discharge.

We reviewed 18 sets of records. Adult records were clear, up-to-date, and available to all staff providing care. The name and grade of the medical professional reviewing each patient, the time of the review, allergies, and notes were signed and dated in 17 out of 18 sets of records.

Our review indicated that, although all electronic information was held appropriately on the system, the same information was not always reflected in the paper records. However, paper records which usually included information from registration, triage and handwritten medical and nursing notes were scanned onto the electronic system once the patient was admitted or discharged.

The electronic system included alerts for patients that had previously attended with mental health symptoms.

The observation ward had implemented a check-list to ensure staff carried out all relevant assessments and checks, and set out expectations of documentation. This included assessment of falls, manual handling, nutritional needs, and was adjusted in line with the patient’s length of stay. For example, patients that were expected to stay longer than six hours had additional assessments undertaken such as the development of safe discharge plans, and screening for methicillin resistant staphylococcus aureus.

Medicines

The service prescribed, gave, recorded and stored medicines well.

Medicines were stored appropriately in locked cupboards. The nurse in charge held the keys for the medicines’ cupboards, including the controlled drugs cupboards. Controlled drugs stocks were checked twice a day; we found only one check that had not been carried out. This was on a weekday morning and had been rectified by the afternoon check. Weekly checks were carried out by the lead nurse. The pharmacy carried out three-monthly checks.

We checked a random sample of medicines in the majors and minors areas which were all found to be within the manufacturer’s recommended expiry dates. We also reviewed a random sample of the department’s controlled drugs; stock tallied with the entries in the controlled drugs register. The register was appropriately completed with two signatures, and we found no discrepancies.

We also checked a random selection of medicines and controlled drugs within the locked storage cupboards in the resuscitation room. Similarly we found no discrepancies with stock, the register, or medicines outside of the manufacturers recommended expiry dates.

We found a box within the controlled drugs cupboard on the observation ward, which was used to store patients’ own medicines. We raised this with the medicines management assistant who acknowledged these should be kept separate, and told us that a new cupboard was to be provided for patients’ own medicines.

We reviewed a random selection of medicines that required refrigerator storage throughout the department. These were within the recommended expiry dates. We reviewed the fridge maximum and minimum temperature logs which were checked daily and completed. Where fridge temperatures were noted to exceed the recommended range, medicines within the fridge were quarantined and subsequently replaced.

A patient group direction, signed by a doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription-only medicines to patients using their own assessment
of patient need, without referring back to a doctor for an individual prescription. Patient group directives were used in the department, but only for pain relief medicines in the triage area.

The department employed a medicines management assistant Monday to Friday. The assistant managed the department’s medicines stocks, reconciled patient medicines, supported staff in obtaining prescriptions and dispensed ‘to take out’ medicines for patients being discharged. This reduced the waiting time for patients to receive their medicines and had a positive effect on the timeliness of patient discharge.

The medicines assistant also pre-prepared trays of commonly used medicines for intensive treatment. This was seen positively and meant medicines were readily available for use in an emergency. A grab bag for treating diabetic people experiencing the symptoms of low blood sugar was prepared with common treatments including glucagen, and sweet biscuits.

Incidents
The service managed patient safety incidents appropriately.

Staff were able to describe the types of incidents that may occur within the department, including near misses. Staff recognised incidents when they occurred and reported them appropriately. The trust had recently introduced a new incident reporting system and provided training on it to staff. Seventy-two hour reviews were undertaken for any incident reported with an impact rating above moderate. Divisional managers escalated relevant reviews to the care organisation leads for a decision on whether or not the incident would be declared as a serious incident. All child deaths were investigated as a serious incident.

Between June 2017 and September 2017, Oldham urgent and emergency services reported two serious incidents. One resulted in severe harm, and one resulted in moderate harm. Both incidents triggered a response by the trust under the Duty of Candour. We reviewed four serious incident reports including the two incidents above, which included root cause analysis assessments, recommendations and action plans. The reports indicated investigations were undertaken, lessons shared, and resulting actions recorded and completed.

Senior managers within the department reviewed, investigated and shared lessons learned from incidents with the whole team and the wider service where appropriate. Weekly meetings were held to review serious incidents, duty of candour implementation, complaints and learning from inquests. Managers shared lessons learnt in a variety of methods; through staff handover safety huddles, staff meetings, hot topics news bulletins and by email. This meant there were opportunities for all staff to receive shared learning, including those returning from leave or on night shifts.

Senior staff understood the requirements of the Duty of Candour. When things went wrong, staff apologised and gave patients honest information and suitable support in line with the principles and requirements of the Duty of Candour.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Urgent and Emergency Care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported 533 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- Eight treatment delay meeting SI criteria
- Five diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- Three medication incident meeting SI criteria
- Two sub-optimal care of the deteriorating patient meeting SI criteria
- One for all other categories

The 514 incidents, which related to 12 hour trolley breaches in accident and emergency, that were pending review at the time we obtained the data, have since been reviewed, downgraded and closed in conjunction with the local clinical commissioning groups.

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)

Following the introduction of the care organisation model, progress was being made by the department to reduce the number of 12 hour trolley breaches and associated number of incidents.

**Safety thermometer**

The service used safety monitoring results well. Staff collected safety thermometer information and used information to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections between August 2016 and August 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment for adults based on national guidance and evidence of its effectiveness.

The urgent and emergency services department used pathways that were evidence based in line with National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These included although were not limited to the fractured neck of femur, sepsis and recognition of stroke pathways.

Staff were able to quickly access policies and procedures for the department, which were held on the trust’s intranet.
The department participated in the national Royal College audits so it could benchmark its practice against other emergency departments.

The department’s trauma team submitted outcome data to the Trauma Audit and Research Network. The network reviewed the data and provided feedback in a themed report which was used to improve the services provided by the department. The trust’s trauma board, which sat across all the trust’s sites, provided multispecialty peer review process. The board reviewed all trauma deaths and trauma related incidents across the trust to identify areas of improvement, and findings were fed into the relevant quality groups.

The trauma team recognised that early trauma identification was a challenge. As such it developed a ‘silver trauma’ recognition tool, which was used to identify trauma injuries in elderly patients that had fallen.

Staff from the rapid assessment, interface and discharge team carried out comprehensive mental health assessments and provided guidance and support to emergency department staff on how patients presenting with mental health needs could be treated signposted, admitted to an acute or mental health inpatient bed, or discharged.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients’ religious, cultural, and other preferences.

A range of hot and cold foods and sandwiches were available to suit patients’ needs, including vegetarian, Halal and Kosher options. Juice and biscuits were provided for children as appropriate.

Patients who required assistance were provided with red tray. This meant that nursing and healthcare assistant staff could easily identify those who needed help.

Staff used a malnutrition universal screening tool to assess all patients for risks of malnourishment.

The waiting room included well-stocked vending machines for people to access while waiting to be seen.

**Accident and Emergency Survey 2014**

In the CQC accident and emergency survey, the trust scored 5.9 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was about the same as other trusts.

(Source: CQC A&E Survey 2014)

**Pain relief**

Staff gave patients pain relief when required. Pain relief, including paracetamol and ibuprofen, could be provided under the pre-authorised patient group directive. Records we reviewed showed that pain relief was prescribed and administered in a timely way when it was required and appropriate. One patient we spoke with confirmed they had been given pain relief when needed.

A visual pain ladder scale, using emojis, was used within the paediatric department. This provided an easy way for children to express the level of pain they were experiencing. Pain in babies was assessed by staff using visual cues.

**A&E Survey 2014**
In the CQC A&E Survey, the trust scored 6.0 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Were you able to get suitable food or drinks when you were in the A&amp;E Department?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service participated in the Royal College of Emergency Medicine audits between 2015 and 2017 but achieved variable results.

The audits against the Royal College’s clinical standards enabled the department to benchmark itself nationally and more locally against the trust’s other emergency departments. Where the audits highlighted areas of concern, the department had taken action to address these.

Royal College of Emergency Medicine Audit: Severe sepsis and septic shock

In the 2016/17 Royal College of Emergency Medicine audit for severe sepsis and septic shock, Royal Oldham Hospital failed to meet any of the standards, however the hospital was in the upper UK quartile for four measures and between the upper and lower quartiles for the remaining four measures.

The measures for which Royal Oldham Hospital performed in the upper quartile were:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival (99.0%)
- Standard 4: Serum lactate measured: Within one hour of arrival (77.0%)
- Standard 5: Blood cultures obtained: Within one hour of arrival (70.7%)
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival (39.6%)

(Source (CQC Insight) Royal College of Emergency Medicine)

Leaders of the service told us they had identified a number of areas for improvement within this audit. This included ambulance pre-alerts for patients suspected of having infection; the identification of data collection issues relating to the commencement of fluids in the ambulance; and prescribing issues in relation to the administration of oxygen. Serum lactate readings (a test for how well oxygen is reaching the body’s cells) are now carried out on all patients and, where appropriate, antibiotics were provided within one hour.


In the 2015/16 Royal College’s audit for vital signs in children, Royal Oldham Hospital was in the upper quartile compared to other trusts for one of the six measures and was in the lower quartile for one of the six measures.

The measure that performed in the upper quartile was:
• Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set (12.5%)

The measure that performed in the lower quartile was:

• There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present) (20.8%)

(Source: Royal College of Emergency Medicine)

In response to this audit, the department introduced and implemented paediatric observations using the Manchester children’s hospital early warning score system. We saw evidence of this, which include age specific guidance, within the department. The department undertook a full set of observations for each child, and had employed a paediatric nurse within the department. The department’s electronic records system had been developed to prevent staff from moving forward unless a full set of observations had been recorded. The department also had at least one advance paediatric life support trained nurse and doctor on every shift.

Royal College of Emergency Medicine Audit: Venous Thromboembolism Risk in Lower Limb Immobilisation in Plaster Cast 2015/16

In the 2015/16 Royal Colleges Audit for Lower Limb Immobilisation in Plaster Cast, Royal Oldham Hospital performed:

• Between the upper and lower quartiles for the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, with a score of 92.3% in 13 cases.

• Between the upper and lower quartiles for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for venous thromboembolism has been given to all patients with temporary lower limb immobilisation’, with a score of 3.9% in 77 cases.

(Source: Royal College of Emergency Medicine)

Royal College of Emergency Medicine Audit: Procedural Sedation in Adults (2015/16)

In the 2015/16 Procedural Sedation in Adults audit, Royal Oldham Hospital was in the upper quartile for one of the measures, the lower quartile for two measures and the middle quartiles for the remaining four measures.

The measure that performed in the upper quartile was:

• Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG (62.0%)

The measures that performed in the lower quartile were:

• Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse (2.0%)

• Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  a. Return to baseline level of consciousness
  b. Vital signs within normal limits for the patient
  c. Absence of respiratory compromise
  d. Absence of significant pain and discomfort
  e. Written advice on discharge for all patients (0.0%)

(Source: Royal College of Emergency Medicine)
Leaders in the service told us an internal documentation audit had been carried out to identify areas of improvement. This had resulted in a new pro-forma being introduced approximately four months previously and education provided to registrars on completion of this. However, the documentation has not been re-audited since to determine if there is evidence of improvement on this standard.

**Unplanned re-attendance rate within 7 days**

Between August 2016 and July 2017, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. In the latest period, July 2017, the trust’s performance was 10.0% compared to the England average of 7.7%.

![Graph showing unplanned re-attendance rate within 7 days for The Pennine Acute Hospitals NHS Trust](image)

(Source: NHS Digital - A&E quality)

The urgent and emergency service at Oldham did not meet its target of less than five per cent unplanned re-attendances within seven days. The rate between October 2016 and September 2017 was consistently worse than target at an average of 7.7%.

Leaders of the service were aware of the high re-attendance rates and told us there appeared to be a correlation with the number of patients leaving the department without being seen. It was hoped that the introduction of the initial assessment and GP streaming service would help to reduce the re-attendance rates. The GP streaming service took the opportunity to encourage patients to see their own GP. The service was also working with the Oldham urgent care alliance network on initiatives to reduce re-attendance rates and on admission avoidance.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance.

The department had a practice based educator to support the training needs for staff, and to oversee the training processes for new and existing nursing staff. The educator undertook educational duties for three days a week and clinical duties for two days a week.

The department had an induction programme for new nursing staff. This included a two-week corporate induction followed by a two-week local induction period at the hospital. New staff then worked on the department for a minimum of a further two weeks to gain experience. During this
time staff were supernumerary, were supported by a mentor/preceptor and were expected to complete and sign-off job competencies as part of the induction programme.

Competency assessment documentation had been developed for a range of competencies including, but not limited to, cardiology, cannulation, phlebotomy, use of medical devices, and plastering. Competency records were subsequently kept electronically and were reviewed yearly by management staff as part of the staff appraisal and personal development review process.

An advanced trauma nurse course was being delivered in the department. All band eight staff had completed these and training was ongoing for band seven and six nurses within the unit.

An eighteen month triage training programme was available for staff that had two years of experience working in the department.

Locum doctors underwent a formal trust locum process. This included directed reading of five key policies and pathways, such as the management of head injury and pyrexial (symptoms of fever) children. The service leaders told us it was advantageous to use internal bank doctors to cover shifts as they were already aware of the departments processes.

The practice educator supported nursing staff with their nursing and midwifery council revalidation. The department held a log of all staff who were due to, or who had already, been through the revalidation process.

Link nurses supported staff in a range of areas including end of life care, organ donation, infection control, pain, new equipment and domestic violence.

Major incident training was included in the departments induction programme for new staff. Training was delivered by the trust’s chemical, biological, radiological, and nuclear lead. The course prepared staff for the use of respiration equipment and protective suits, and reviewed the hospital’s major incident plan and staff roles within this.

The chemical, biological, radiological, and nuclear lead was in the process of reviewing and updating the trust’s plan to reduce the overall size of the document, and to individualise it for the needs of the site.

### Appraisal rates

Appraisals were carried out over a rolling twelve-month period against the trust’s annual target of 90%. Data provided at the time of the inspection demonstrated that 97% of eligible nursing and midwifery staff in the urgent and emergency services department had received an appraisal.

NB– data from the following teams have been used for the below as the trust didn’t include a specific Urgent and Emergency Care core service for the appraisal data supplied in the RPIR:

352 BD115 - UCC Clerical (Rochdale), 352 BD311 - Urgent Care Centre (Rochdale), 352 BE404 - Urgent Care Teams, 352 CB100 - Urgent Care Mgmt (Bury), 352 CB102 - Urgent Care Mgmt (Oldham), 352 CB105 - A & E Clerical Support (Bury), 352 CB110 - A&E Reception (North), 352 CB113 - A & E Clerical (Oldham), 352 CB305 - Accident & Emergency (Bury), 352 CB307 - Accident & Emergency (North), 352 CB309 - Accident & Emergency (Oldham), 352 CB322 - A&E - ENPs (North), 352 CB324 - A&E - ENPs (Oldham)

Between June 2016 and May 2017, 69% of staff working within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%.

The 69% appraisal rate applies to nursing and midwifery registered, additional clinical services staff, allied health professionals, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Royal Oldham Hospital 87% had received an appraisal

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We observed effective multidisciplinary working between all groups of staff.

Staff attended shift handover meetings, also known as safety huddles, twice a day at 7.30am and 9.15pm. This ensured that relevant patient information, safety information, and learning was shared with all relevant staff at the start of each shift.

Staff from the department attended the multidisciplinary meetings each weekday on the acute medical unit. Representatives from the consultant group, junior doctors, nursing physiotherapy, and occupational therapy, pharmacy and care of the elderly teams attended. The meeting aimed to set goals for patient progress and to identify patients who could be discharged.

Staff worked closely with, and received specialised support from the rapid assessment, interface and discharge team mental health nursing team and were able to directly refer appropriate patients requiring mental health assessment to the team.

Staff in the department worked closely with the service’s therapy team, which was managed by another provider. The team supported patients in the department and with rehabilitation of patients on the observation ward. The team were able to refer patients to community intermediate care beds. The team also aimed to avoid patient admissions to hospital where possible, and had a ‘deflection rate’ of 85%. This was achieved through close liaison between the team’s occupational therapists, physiotherapists, housing officer and community services including social services.

Seven-day services

The urgent and emergency service at Oldham was open 24 hours a day, seven days a week. x-ray facilities were co-located to the department and could be accessed during the same operational hours. Pharmacy, physiotherapy, and pathology services were also available seven days a week.

Patients presenting with mental health issues could be referred to the on-site rapid assessment, interface and discharge team for assessment. The team worked 24 hours a day, seven days a week.

Health Promotion

Staff in the urgent and emergency department promoted smoking cessation to every patient admitted who smoked.

The department supported a first aid course for the public.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always know how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We were informed that training in the Mental Health Act 1983 and the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included in the department’s safeguarding mandatory training. The alcohol liaison link nurse had recently provided training to some staff in the department who felt they had benefitted from it. However, the trust’s mandatory training tracker identified a separate Mental Health Act / Mental Capacity Act level one training module which had
yet to be implemented. One hundred and seven nursing and health care assistant staff across the trust were identified as requiring this training. This appeared to be supported by comments we received from staff who told us they did not receive any specific mental health training. Staff told us this training would be useful as they deal with patients with mental health issues on an almost daily basis.

We observed staff taking consent appropriately. This included both verbal and implied consent. Staff understood their duties to ensure patients had capacity to consent. Where a patient potentially lacked capacity, nursing staff escalated this to the medical team to carry out a formal assessment of the patient’s capacity. A doctor we spoke with told us they would undertake a two stage capacity assessment and, where a patient lacked capacity to make a decision, would document the best interests decision within the patient’s notes. Decisions to apply for a Deprivation of Liberty Safeguarding order were only made following formal assessment and decision by the medical team.

**Mental Capacity Act and Deprivation of Liberty training completion**

Data for this metric was not provided.

*(Source: Trust Provider Information Return P14/P49)*

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**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion.

We observed kind, caring, and compassionate interactions between staff and patients. A named nurse was allocated to each bay. We observed staff introducing themselves to patients using the ‘Hello, my name is’ structure. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 3: “Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.”

Patients we spoke with were positive about the care provided. One told us that staff were “courteous”, while another said that the treatment was “excellent” and that staff had been “attentive to my needs and professional”. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 1: “Patients are treated with dignity, kindness, compassion, courtesy, response, understanding, and honesty.”

Patients’ privacy and dignity was maintained with cubicle curtains consistently drawn while patients were receiving care and treatment, or when friends and family were present. We observed a patient’s dignity being maintained during an electrocardiogram trace, and the patient was also given a blanket as they felt cold. This was in line with the Royal College’s Emergency Department Care (2017) Quality Standard QS4.

However, one patient told us they had been left in a corridor as there were not enough porters in the afternoon to take the patient to or back from the scan; the patient told us a doctor brought them back to the department after the scan. This was reflected by a porter we spoke with who noted that, at busy times, demand for portering services in the department sometimes exceeded capacity.

Staff told us of an example where they had facilitated the discharge home for a patient at the end of life so that the patient could be with their partner of 72 years before they died.

**Friends and Family test performance**

Between July 2016 and June 2017 the trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was consistently worse than the England average. In the latest period, June 2017 the trust’s performance was 83.7% compared to the England average of
In June 2017 85% of patients in Oldham said they would recommend the urgent and emergency service. The figure was 81% in July, 83% in August and 81% in September. The department had also received 25 compliments in September.

### A&E Friends and Family Test Performance - The Pennine Acute Hospitals NHS Trust

![Graph showing A&E Friends and Family Test Performance](image)

(Source: NHS England Friends and Family Test)

### Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff were aware of the impact on patients and carers as a result of the care and treatment provided. Staff undertook comfort rounds every hour to check on patients and to ensure their needs were met. This included checking that patients could reach their possession and the call bell. This was in line with National Institute for Health and Care Excellence Quality Statement QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety. The department was able to chaperone any patient that requested it.

Patients experiencing mental health symptoms were treated within a designated side-room next to the nurses’ station. Staff referred patients appropriately to the on-site rapid assessment, interface, and discharge team. This meant that patients with mental health and alcohol or substance misuse problems were supported with early psychiatry liaison and assessment.

Relatives and carers of patients who had died in the hospital had access to the hospital chaplaincy service. A spiritual care box, including religious texts, and end of life personal care packs were available within the Swan Suite to provide additional support to relatives and carers. This was in line with the Royal College of Emergency Medicine guidance on emergency department care quality statement QS9: “in the case of a dying or recently deceased patient, is the relevant clinical area quiet, private, sensitively designed and readily identifiable as such to approaching staff?”

Staff told us about how they had supported a patient in the department who was at the end of their life. The partner of the patient’s son had just given birth to a baby in the hospital. Staff arranged for the baby and mother to be brought down so that the patient could see their grandchild before they passed away.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

One patient we spoke to told us they had received “perfect treatment. The doctors have gone out of their way to answer questions and are well mannered and considerate.”

A carer, who was attending with her pregnant daughter and grandson, told us that staff had been “brilliant” and had updated them, and staff in the labour ward, with the patient’s progress.

We observed staff explaining the need for a blood test to a patient and asking for consent to take this. Staff updated the patient and their family on the results of investigations and tests.

We observed one patient refusing treatment. Nursing staff explained the proposed treatment to the patient, the benefits and consequences of the treatment and provided reassurance. Staff gave the patient time to think and to assess the information that had been provided. The patient subsequently agreed to treatment within their own defined parameters. This was in line with the National Institute of Health and Care Excellence QS15 statement 4: “Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care”.

In the paediatrics department staff used visual tools such as an emoji pain ladder to understand children’s levels of pain. Parents attending the children’s accident and emergency department said staff were attentive to children, commenting that: “staff were professional, competent and well trained, they understand children’s needs. The staff looked like they wanted to be here, there was a good atmosphere.

Bed-side nursing handovers had been implemented in the observation ward. This ensured that the patient was introduced to the staff caring for them, but was also involved in discussions about their care.

A&E Survey 2014

The results of the CQC A&E survey 2014 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>2014 RAG</th>
<th>Trust 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Were you told how long you would have to wait to be examined?</td>
<td>About the same as other trusts</td>
<td>4.44</td>
</tr>
<tr>
<td>Q10. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>About the same as other trusts</td>
<td>8.15</td>
</tr>
<tr>
<td>Q11. While you were in the A&amp;E Department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>7.97</td>
</tr>
<tr>
<td>Q12. Did the doctors and nurses listen to what you had to say?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q15. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>About the same as other trusts</td>
<td>8.70</td>
</tr>
<tr>
<td>Q16. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>About the same as other trusts</td>
<td>7.42</td>
</tr>
<tr>
<td>Q17. While you were in the A&amp;E Department, how much information about your condition or treatment was given to you?</td>
<td>About the same as other trusts</td>
<td>8.58</td>
</tr>
<tr>
<td>Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>About the same as other trusts</td>
<td>7.84</td>
</tr>
<tr>
<td>Q20. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Question</td>
<td>2014 RAG</td>
<td>Trust 2014</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>About the same as other trusts</td>
<td>7.76</td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity while you were in the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>8.54</td>
</tr>
<tr>
<td>Q13. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>About the same as other trusts</td>
<td>7.04</td>
</tr>
<tr>
<td>Q22. If you were feeling distressed while you were in the A&amp;E Department, did a member of staff help to reassure you?</td>
<td>About the same as other trusts</td>
<td>6.08</td>
</tr>
<tr>
<td>Q24. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.26</td>
</tr>
<tr>
<td>Q25. Before you left the A&amp;E Department, did you get the results of your tests?</td>
<td>About the same as other trusts</td>
<td>8.24</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.49</td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>About the same as other trusts</td>
<td>5.22</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>About the same as other trusts</td>
<td>4.66</td>
</tr>
<tr>
<td>Q39. Did hospital staff take your family or home situation into account when you were leaving the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>4.67</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>About the same as other trusts</td>
<td>5.30</td>
</tr>
<tr>
<td>Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&amp;E Department?</td>
<td>About the same as other trusts</td>
<td>6.99</td>
</tr>
<tr>
<td>Q43. Overall... (please circle a number)</td>
<td>About the same as other trusts</td>
<td>7.80</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care and treatment in a way that met the needs of local people.

People attended the service primarily from the local population in the Oldham area, although the service also received patients from the Rochdale area.

The department’s facilities and premises were appropriate for the services provided. GP streaming services had been put in place to treat suitable patients.

The service worked with the local clinical commissioning group and the Oldham urgent care alliance to identify and reduce the number of avoidable admissions.
Patients who required additional support, such as those living with dementia, at risk of falls, or who needed assistance with eating were appropriately identified and care adjustments made accordingly. The service had a learning disability nurse.

The service had a winter pressures plan which was developed in conjunction with the urgent care alliance network. This included identifying opportunities for integrated therapy in the community, transitional bed capacity and residential home spaces. The department increased the number of paediatric consultant sessions between 5pm and 10pm with a centralised booking system with the aim of reducing the number of child referral and readmissions by GPs.

The service identified that referrals to the child and adolescent mental health service for paediatric patients needed to be made before 12 noon, otherwise the service would not be able to see the child until the following day. This issue was further compounded if a child was discharged as the mental health service would not then see the child for seven days. As a result this meant that children sometimes needed to be admitted to the hospital over a weekend. The service was working with the local mental health provider and the clinical commissioning group to understand how it could manage the situation, improve the patient pathway and to determine if patients could be funded for treatment in a different area.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

A range of patient information leaflets were available within the department. Although there was a significant minority ethnic population in the Oldham area, the majority of leaflets were in English. Staff told us that translation for Polish and Romanian patients was an issue; although some staff in the hospital were able to speak Polish. However, copies of leaflets in other languages were available online for staff to print off when required.

Staff understood the importance of not relying on patients’ families or carers to interpret important information and conversations. Interpretation services were available by telephone, and face-to-face when appropriate; this included British sign language.

Patients with a diagnosis of living with dementia were identified by the use of a blue wristband and the forget me not symbol. The department held a memory box to support patients who were living with dementia while in the department. The observation ward included a dementia friendly memory room where patients could eat their dinner. Dementia friendly clocks, displaying the date as well as time, were used in the department.

Patients with mental health needs presenting within the emergency department were referred and seen by trained mental health staff working in the rapid assessment, interface and discharge team, including mental health staff trained to work with older adults with organic mental disorders such as those living with dementia. Staff in the team had access to the mental health NHS trust patient records to check if patients were already known to mental health services. This enabled staff to identify the support and treatment patients were given by community mental health services to ensure patients received appropriate and continuous treatment.

The service worked with a Red Cross team contracted by the clinical commissioning group to support patients being discharged. The team, which worked Monday to Friday between 11am and 7pm transported up to approximately 11 patients home per day with any necessary equipment. Wheelchair loan was available to patients to enable earlier discharge while waiting for a permanent chair to be provided. Contact was made with each patient’s relatives or carers to inform them of the discharge, and follow-up calls were made with the patient a few days after to check if there were any issues. The team were able to support patients for up to approximately six weeks after discharge.

Dynamic risk assessments were carried out for any patients presenting with mental health symptoms by the rapid assessment, interface and discharge team. Patients who, following assessment, were identified as needing a mental health specific bed were kept in the department until a formal mental health act assessment was carried out. The team’s staff told us this could
prove challenging out of hours, as there was no on-call rota for approve mental health professional and appointed doctor, and would require the team to ring round a contact list.

The urgent and emergency services department had a dementia link nurse. Eighty-one per cent of nursing and healthcare assistant staff had completed the level one dementia awareness training. The department implemented the ‘this is me’ information leaflet for patients living with dementia and supported John’s Campaign.

A&E Survey

The trust scored “about the same” as other trusts for the three A&E Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
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<td>9.00</td>
<td>About the same as other trusts</td>
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(Source: CQC A&E Survey 2014)

Access and flow

People could access the service when they needed it. Median waiting times for triage within 15 minutes were in line with good practice, at between eight and ten minutes between October 2016 and September 2017. The highest median triage time was during the winter months.

However, between October 2016 and September 2017 the service did not meet the national target for decisions to admit, treat, and discharge 95% patients within four hours. Although improving, monthly performance consistently remained below 87% and only met the externally agreed trajectory target between April 2017 and June 2017.

During the inspection, we observed the flow of patients and reviewed current information on waiting times. We reviewed waiting times recorded in 18 sets of records.

Royal College of Emergency Medicine guidance indicates that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Patients attending the Oldham department unplanned (walk-in) were triaged by a nurse following registration within 15 minutes of arrival in 14 out of the 18 records. In six of fifteen eligible records, the patients were reviewed within one hour of arrival, seven were not reviewed within this timescale, and for the remaining records either the time was not recorded or we were unable to determine the time of review.

Patients assessed as being suitable to stream to the GP service were identified at triage. The GP service, which was contracted by the local clinical commissioning group, was available seven days a week between 11am and 11pm. Patients with minor illnesses were streamed to a see and treat service led by emergency nurse practitioners.

The department had future plans to increase the number of ambulance triage cubicles from one to three, which it was hoped would improve flow.

An acute physician was based in the department to identify patients that were suitable to be transferred to the ambulatory care unit for treatment.
Patients suspected of, or identified as, having trauma injuries were fast-tracked at triage using a defined assessment pathway. This ensured that whole body computed tomography scans were requested and carried out in a timely manner.

The paediatrics department worked closely with the children’s ward flow co-ordinator to make effective use of available beds for children that needed to be admitted. However, although this had helped make some improvements in patient flow, staff told us the limited number of beds on the children’s ward meant that, with increasing demand, during busy periods children may stay longer in the department while waiting for a bed. This was reflected by comments we received from a number of parents and carers who reflected that, on some occasions, waiting times were long. Staff told us that, on occasions, patients were transferred to another hospital in the region for admission rather than waiting in the department.

The department was part of the Oldham urgent care alliance and worked with the in-house therapy teams, a local mental health trust, local authority, social services, housing and GP services. The aim of the alliance was to reduce pressure on the department, improve the flow of patients back into the community, and to avoid admissions of patients in the department who required support but did not requiring admission to hospital.

Daily bed meetings (at 9am, 1pm and 4pm) were attended by representatives from across all areas of the hospital. We observed meetings at 9am and 1pm, which were chaired by senior leaders in the hospital. The meeting reviewed all potential twelve hour breaches and ensured plans were in place for progression the admission, transfer or discharge of the relevant patients. Staff at the meetings identified any departmental issues, including staff shortages. A proactive approach was taken to sharing and moving staff to support areas experiencing shortages.

The mental health rapid assessment, interface and discharge team operated 24 hours a day, seven days a week. Breaches in the four-hour target for decision to admit, transfer or discharge or the 12-hour trolley wait target for patients presenting with mental health symptoms were usually due to the need for the patient to undergo a Mental Health Act assessment or if a child or young person needed a specialist children’s and adolescent mental health bed. This was beyond the full control of the staff in the emergency department or the rapid assessment, interface and discharge team. It usually related to awaiting attendance from the approved mental health professional to coordinate the Mental Health Act assessment, awaiting assessing doctors external to the hospital, or sourcing an appropriate bed.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E.

The trust failed to meet and subsequently breached the standard for each month during the period September 2016 to August 2017.

From March 2017 onwards performance against this metric has shown a general trend of improvement, peaking in May 2017 but still showing an upward trend towards the standard for June 2017 to August 2017.

Throughout the period the trust’s performance, although consistently below the England average, has followed a similar trend to it.

**Four hour target performance - The Pennine Acute Hospitals NHS Trust**
The urgent and emergency service at Oldham did not meet the national 95% four-hour standard for the period October 2016 to October 2017, with the average daily number of breaches at 63. Average performance during this period was 78%. Although improving individual monthly performance remained consistently below 87%. The service only performed better than the external target trajectory for three months between April and June 2017. This target had been agreed with the Greater Manchester Health and Social Care Partnership as part of the service’s improvement plan.

The department’s leaders told us a number of breaches related to delays in waiting for computed tomography scanning as the hospital had only one computed tomography scanner. A second scanner was being installed during our inspection. It was hoped this would reduce associated delays. It was also hoped that the nurse lead initial assessment and triage with streaming to GPs and minor injuries being treated by emergency nurse practitioners, would begin to reduce the number of four hour breaches.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between September 2016 and August 2017 the trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was higher than the England average.

Performance against this metric showed a trend of improvement from October 2016 onwards where the percentage of patients waiting between four and 12 hours has decreased steadily, moving closer in line with the England average. May 2017 saw the lowest percentage of patients waiting between four and 12 hours throughout the period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Pennine Acute Hospitals NHS Trust**
Between October 2016 and September 2017, the urgent and emergency service at Oldham showed a similar steadily decreasing trend in the number of patients waiting in the department between four and 12 hours. This resulted in a drop from 590 patients waiting for this period in October 2016 to 280 patients in September 2017.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from September 2016 and August 2017, 721 patients waited more than 12 hours from the decision to admit until being admitted.

The highest numbers of patients waiting over 12 hours were in October 2016 with 129 patients, January 2017 with 125 patients and February 2017 with 113 patients.

For October 2016 and February 2017 the trust had the highest number of patients waiting over 12 hours out of all NHS acute trusts.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-16</td>
<td>1137</td>
<td>36</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1633</td>
<td>129</td>
</tr>
<tr>
<td>Nov-16</td>
<td>1623</td>
<td>84</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1569</td>
<td>86</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1404</td>
<td>125</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1122</td>
<td>113</td>
</tr>
<tr>
<td>Mar-17</td>
<td>931</td>
<td>73</td>
</tr>
<tr>
<td>Apr-17</td>
<td>899</td>
<td>40</td>
</tr>
<tr>
<td>May-17</td>
<td>683</td>
<td>9</td>
</tr>
<tr>
<td>Jun-17</td>
<td>763</td>
<td>1</td>
</tr>
<tr>
<td>Jul-17</td>
<td>824</td>
<td>22</td>
</tr>
<tr>
<td>Aug-17</td>
<td>675</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)
Following the introduction of the care organisation model, progress was being made by the department to reduce the number of 12 hour trolley breaches. Between October 2016 and March 2017 the department had an average of 20 breaches per month. This reduced to an average of five per month for the period April to September 2017. Notably it had no 12 hour breaches in May and June 2017 and there were significant dips to single figures in the number of patients in December 2016, March, April, August and September 2017.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

Between September 2016 and July 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was higher than the England average. However performance against this metric has shown a trend of improvement with the median percentage decreasing slightly from its peak in December 2016.

From May 2017 onwards performance has become more in line with the England average. In the latest period, July 2017, the median percentage for the trust was 3.5%, compared to the England average of 3.4%.

**Percentage of patient that left the trust without being seen - The Pennine Acute Hospitals NHS Trust**

(Source: NHS DIGITAL - A&E quality indicators)

The urgent and emergency service at Oldham consistently met the five per cent target of patients leaving the department without being seen. There did not appear to be any specific overall trend to this performance measure with performance varying between three per cent and five per cent with an average monthly rate of 3.8%.

**Median total time in A&E per patient (all patients)**

Between September 2016 and July 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. May 2017 was the month where the trust’s median total time in A&E of 151 minutes was closest to the England average of 148 minutes.

**Median total time in A&E per patient - The Pennine Acute Hospitals NHS Trust**
Between November 2016 and October 2017, the median total time in the department for patients who were admitted was 264 minutes. For patients who were not admitted the median total time in the department was 158 minutes.

A&E Survey

The trust scored “about the same” as other trusts for the three A&E Survey questions relevant to the responsive domain.

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<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC A&E Survey 2014)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Between June and September 2017, the hospital received seven complaints about care and treatment provided by the Oldham urgent and emergency service. This was lower than the number of complaints received about the trust’s other urgent and emergency sites.

Complaints were co-ordinated by the trust’s complaints team and sent to the department for investigation. Senior nursing staff in the department investigated complaints. Informal concerns, arising at the time of the patient’s attendance, were addressed by staff at the time and documented in the patient’s notes.

Feedback was provided individually to any staff member involved in the complaint in a supportive manner with any relevant training needs identified. Learning from complaints was shared more widely with the team at team meetings, within daily safety huddles (and repeated for seven days to ensure the majority of staff had the opportunity to receive the learning), in hot topics newsletters and emails.

(Source: NHS DIGITAL - A&E quality indicators)
Learning from safeguarding concerns was also shared in the seven-minute briefings, and in the quarterly safeguarding bulletin. Safeguarding was included as a standing agenda item at the monthly nursing and midwifery forum.

**Summary of complaints**

Between June 2016 and May 2017 there were 149 complaints about Urgent and Emergency Care services (18.3% of all complaints).

The trust took an average of 63 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 here were 39 complaints still open and yet to be completed.

There were 93 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 62%.

Royal Oldham Hospital: There were 44 complaints (29.5%)

*Source: Routine Provider Information Request (RPIR) P61 Complaints*

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Since the last inspection, the trust has undergone significant restructuring with the introduction of the local care organisation model in January 2017. The Oldham care organisation leaders had responsibility for the site. The care organisation was led by a team consisting of a managing director/chief operating officer, a medical director, a director of nursing and a finance director. The organisation was supported by a clear governance structure and clear lines of accountability for staff at all levels. Staff spoke positively about the introduction of the care organisation model.

The urgent and emergency services at Oldham were provided by the emergency and urgent care directorate within the medicine division. The division was led by the clinical director, director of nursing, and managing director. The directorate was led by the directorate manager, clinical director, assistant director of nursing, with a clinical lead for the accident and emergency department and a clinical lead for the acute medical unit.

The departmental, directorate and divisional leaders we spoke with understood the challenges facing the service, which included staffing levels, incidents, and complaints. The leaders were also able to clearly describe the actions that had already been taken, or were planned to be taken, to meet these challenges. The associated director of nursing and safeguarding and the lead nurse for the department were motivated to improve the service provided by the department.

The majority of staff we spoke with were aware of who the care organisation and directorate leaders were. Senior staff, including the care organisation, divisional and directorate staff were visible on the unit for walk rounds and also undertaking clinical duties when needed.

We observed senior leaders within the unit working with the teams in an approachable manner. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standard 14.

**Vision and Strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action.
Leaders and senior staff within the urgent and emergency service had a clear understanding of the challenges faced by the department. They were able to describe the department’s strategy for improving performance, which focused on delivering appropriate staffing levels including recruiting and increasing the department’s consultant cover to 16 hours per day seven days a week.

Further staffing plans included increasing the ‘depth of cover’ into the evenings to ensure senior staff were available at times of peak demand. This included the use of emergency nurse practitioners and advanced nurse practitioners to support the flow of patients requiring treatment.

The strategy included assessment of the staffing level models, the implementation of the GP streaming initiative, and plans to introduce an advanced nurse practitioner role to ‘float’ and support the team.

However, staff we spoke with remained concerned about the physical capacity of the paediatrics department to meet the increasing demand on its services, particularly in the period from mid-afternoon into the evening and night.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff at all levels in the urgent and emergency services department spoke positively about the introduction of the care organisation model. Staff told us there had been an improvement in culture in the department over the past year. One nurse told us they had worked in the service as a student and part of their decision to apply to work at the trust after qualification was due to the support provided to staff within the department. The nurse told us they ‘can go and talk to anyone for help’.

Staff were motivated, proud and felt supported by their managers to provide good quality care. The culture encouraged openness and honesty at all levels in the department. Staff were supported to report incidents and feedback to individuals was provided in a positive way. We saw no evidence of a ‘blame culture’ in the department. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standards including QS12, QS18, QS21, and QS50.

Nursing and medical staff we spoke with told us they felt listened to, that doctors were open to challenge and staff felt able to speak up to the senior staff. This included pausing any procedures if they had any potential safety concerns. Staff confirmed that the divisional directors were visible within the department.

**Governance**

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a clear governance structure and clear lines of accountability for staff at all levels. Staff were clear about their roles within the new structure, what they were accountable for, and to whom. There was a clear escalation and governance committee structure in place with lines of sight to the care organisation director team. This included quality, risk and operational performance and patient experience committees, including mortality and morbidity review following the death of patients who had received treatment in the department.

The urgent and emergency services at the trust were measured against a range of performance criteria, which was held in dashboard for each department. There were improvements in a number of performance measures for the urgent and emergency services since the implementation of the
care organisation model, including a reduction in the number of 12-hour trolley waits. However, the leaders acknowledged there was still room for further improvement to meet key national targets.

The trust has signed up as a partner agency (through the Greater Manchester acute trust chief executive's group) to the local mental health crisis care concordat agreement and action plan. The concordat was a national agreement between services and agencies involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people get the help they need when they were having a mental health crisis.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Divisional, directorate and department leaders were able to describe, understood and had oversight of the risks and issues affecting the urgent and emergency service at Oldham. These included staffing levels, increasing demand on the existing physical capacity, and performance including ambulance handover times, time to triage, and time to assessment.

Risk and clinical performance was monitored through the divisional quality assurance and risk committee, which met monthly. Risks with a score higher than six were escalated to the monthly quality, patient experience, and clinical effectiveness committee.

The core organisation assurance and risk committee oversaw risks scoring 10 or higher. These were fed into the care organisation's board assurance framework and risk register and enabled the care organisation to develop and set its assurance statements for the group risk and assurance committee.

We reviewed the divisional risk register for Oldham. This included risks we expected to see such as capacity and demand in adults, paediatric and trauma areas; staffing levels and skill mix; delays in triaging of patients; delays in assessment of trauma injuries; delays in mental health and child and adolescent mental health assessments, delayed transfers of care and incidents.

The register identified the key control measures and gaps for each risk, the likelihood and impact of each risk, the assurance measures and gaps, an action plan for each risk, and an assessment of the 'risk tolerance level'. However, it was not clear when each risk had been entered onto the register and, as such, it was not possible for us to accurately determine if control measures and action plans had been identified in a timely way.

Performance was monitored monthly through divisional management meetings, and against national and NHS Improvement targets and trajectories. This fed into the divisional operations and performance committee, through the operations, performance and finance information committee, and similarly into the monthly care organisation assurance and risk committee. A dashboard enabled senior staff to compare performance of the individual departments, and the urgent and emergency service across the trust as a whole. Themes such as extended waits, patient flow performance, incidents were aligned with the risk register and were reviewed on a weekly basis and fed into the urgent care improvement plan reviewed on a weekly basis.

Learning from risks, incidents, complaints and safety alerts was shared with staff in a variety of methods including email, hot topics newsletters, and the daily safety huddles. Relevant information was repeated in safety huddles for seven days to ensure that the majority of staff received the information.

The department had rolled out Sepsis Six care bundle training in line with National Institute for Health and Care Excellence Guideline NG51 Sepsis: recognition, diagnosis and early management. The Sepsis Six aimed to implement three diagnostic and three therapeutic actions within one hour of a diagnosis of potential sepsis. These included monitoring of oxygen levels, fluids and urine output, measurement of lactate levels and the commencement of blood culture tests and antibiotics. The department had achieved 96% training compliance for all eligible nursing staff.
The department contributed to the monthly mortality and morbidity review for patients that had died within 24 hours of receiving care in the department. The deaths were reviewed by senior medical, nursing and allied health professional staff and learning shared with staff and feedback to the executive Clinical Effectiveness Committee chaired by the trust Chief Medical Officer.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan and staff were aware of where the plan could be accessed.

The department and hospital responded to the Manchester Arena bombing. The leaders told us that staff were supported by the matron and consultant but that, in the event staff on duty were appropriate for the types of injuries patients were presenting with; it was not necessary to request additional staff to attend. The trust provided support and counselling services for staff involved. Debriefing sessions were subsequently arranged which included learning from the event.

**Managing Information**

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems.

Performance information was collected and analysed by the department and used to develop and support the services the department offered. This included the collection of data to support national audits and surveys including those by the Royal College of Emergency Medicine, the Safety Thermometer, the NHS Friends and Family Test, and interactions with the ambulance service.

Performance data was benchmarked against urgent and emergency services in the trust’s other care organisations, against the trust performance as a whole, and where appropriate against national standards.

Staff had access to the relevant information needed to care for their patients. However, staff told us they had experienced issues with responsiveness of the trust’s information management and technology systems at busy times of the day. This was a particular issue with accessing test results from the trust’s pathology lab system, and was a known issue at trust level and was included on the risk register.

**Engagement**

The service engaged with patients, staff, and the public and local organisations to plan and manage appropriate services.

The department participated in the NHS Friends and Family scheme. Senior staff reviewed the comments provided.

Patient comment cards were available in the department.

The department participated in the trust’s 1000 voices events which aimed to engage and capture staff views and ideas on the trust’s reorganisation and improvement programme. A monthly Team Talk was facilitated by directors to deliver important messages. Staff also received updates through departmental newsletters and emails.

The division and department engaged in and promoted the ‘Healthy, Happy, Here’ programme. The programme aims to promote and improve the health and wellbeing of staff. The department introduced long-day shifts for staff that wanted them; which provided more flexibility for staff. Similarly, portering staff we spoke with told us the service had worked to provide them with the shift patterns they requested.

The department participated in the trust’s ‘Glimpse of Brilliance’ award scheme. Thank you messages, including emails from the director team, were displayed in the staff areas.
Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There was a culture of supportive learning and improvement embedded in the department, which extended to the training of new doctors and nurses. At least one staff member told us they had specifically joined the department following qualification as a result of the supportive nature.

All managers within the department were involved in the review and investigation of incidents and complaints and learning from these was shared with staff through a range of media including written and face-to-face communications.

Continuous improvement was highlighted by the observation ward which had achieved a green rating in the trust’s nursing assessment and accreditation system. The system measured the quality of nursing care delivered in the department and incorporated the essence of care standards, key clinical indicators and linked each question to compassionate care.

The department’s emergency medicine website was built by consultants to support trainee doctors and locum staff.

Staff told us about the learning undertaking following a trauma incident, which had arisen due to delays in assessing the trauma injury and recognising that the patient had internal bleeding. As a result a trauma assessment pathway sheet was developed, suspected trauma patients assessed by a trauma doctor on arrival, and referral for full body CT scan for trauma patients was implemented.

Medical care (including older people’s care)

Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all trust services).
The Royal Oldham Hospital provides medical care which covers a range of specialities, including cardiology, coronary care, respiratory, and diabetes/endocrinology, general medicine, haematology and care of the older person.

Additionally there is a discharge ward and discharge lounge which can also accommodate up to six sub-acute rehabilitation patients.

There are strong links with Oldham Urgent Care Alliance partners and joint working around the integrated discharge team and discharge to assess service.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 84,153 medical admissions between June 2016 and May 2017. Emergency admissions accounted for 43,207 (51.4%), 1,779 (2.1%) were elective, and the remaining 39,167 (46.5%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 45,655
- Gastroenterology: 12,034
- Clinical Haematology: 11,993

(Source: CQC Insight)

### Is the service safe?

**Mandatory training**

During our inspection, we found that managers did not always ensure that staff had completed mandatory training.

Nursing staff we spoke to told us that managers were proactive in ensuring they were up to date with mandatory training and encouragement from managers had improved since our last inspection.

Rates for completion of mandatory training among medical staff were lower and the medical staff we spoke to told us there was limited opportunity for training.

**Mandatory training completion rates**

The trust set a target of 90% completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in the Medicine division are shown below:
Medical and dental staff in the medicine division failed to meet the 90% target for mandatory training compliance for all of the 16 modules.

Basic life support training had the lowest compliance levels with only 36% and 52% of eligible medical and dental staff having been trained.

Nursing and midwifery staff in the medicine division met the 90% target for mandatory training compliance in two modules (waste management and infection prevention non-patients).

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding
Staff understood and were able to explain how to raise a safeguarding concern if they thought a patient maybe at risk of harm.

The trust’s safeguarding policy was available to staff via the online system and staff told us that when they had made a referral to the safeguarding team, this was responded to in a timely manner.

Safeguarding processes for child exploitation and female genital mutilation (FGM) were covered as part of mandatory safeguarding training for all staff.

We found that patients at risk of suicide or self harm were not always assessed appropriately and arrangements made so that they would remain safe. For example, in the acute medical unit we observed two patients at risk who were staying in a room which contained a number of ligature points without this risk being assessed. The trust later told us that the risk to these patients had been mitigated by implementing additional observation alongside hourly intentional rounding.

Uptake of safeguarding training was inconsistent throughout the hospital and overall the trust target of 90% was not met for level 3 safeguarding training.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing staff working in the Medicine division is shown below:

![Safeguarding Training Completion by module](chart)

The 90% target was not met for any of the safeguarding modules by medical and dental staff in the medicine division at the trust. Level 2 adults and children’s training was completed by 251 and 250 of the 294 eligible staff members, however this didn’t equate to 90% compliance.

Compliance for level 3 adults was the lowest, with only 56 of the 110 eligible staff members completing the training.
Nursing and midwifery staff in the medicine division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We found effective systems were in place to prevent and control the risk of infection.

During our inspection, we found that clinical areas were visibly clean and tidy. Patients and relatives told us that wards were always kept clean and they had observed staff cleaning their hands regularly.

There was a trust-wide infection prevention and control policy. We reviewed areas including the sluice, administration stations and relatives waiting areas and found them to be clean and tidy. We observed staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care. We observed medical and nursing staff following the trust policy for hand washing and ‘bare below the elbows’ guidance in clinical areas. There were adequate hand-washing facilities throughout the department and hand gel dispensers were available in each cubicle.

We looked at cleaning cupboards on wards and saw that equipment such as coloured mops and buckets were available and stored correctly. Cleaning chemicals had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.

Handwashing; catheter and cannula audits were carried out by infection prevention and control link nurses to ensure compliance with National Institute of Health and Care Excellence (NICE) guidance to reduce the risk of infection. A patient hand hygiene audit had recently been introduced and had good results. We saw that the results of such audits were displayed on notice boards in each of the wards we visited.

Environment and equipment

The service had suitable premises and equipment available to meet the needs of the patients.

We observed that equipment such as hoists and pressure relieving mattresses were readily available on the wards and were used for patients as needed.

The monitoring of emergency resuscitation equipment had improved since our last inspection. All of the emergency trolleys we looked at were stocked correctly and located in an area which was
easy to access in the event of an emergency. All trolleys sampled contained consumables which were within the expiry date. The relevant equipment was checked on a daily basis ensuring that if the equipment was needed it was suitable to meet the needs of patients.

The environment was suitable for care and treatment and adaptations were made, where necessary, to meet the needs of patients. For example, a dementia garden had been developed on ward G1 for patients to use as they wished.

Assessing and responding to patient risk

Risks to patients were not consistently recognised and addressed. Although we saw evidence of good practice in some areas of the hospital, this was not apparent across the whole service.

We saw from patient records that medical patients were reviewed by a relevant consultant within 12 hour of admission and that patients with suspected sepsis received antibiotics within an hour and had the necessary blood tests to confirm suspected sepsis. Patients with suspected sepsis had their condition monitored using Early Warning Scores but we saw in one patient's record that their blood results had not been reviewed as soon as they were available although this did not impact the care they received.

Records reviewed showed that there had been an improvement in monitoring and recognising changes in patients’ conditions. The monitoring system known as Early Warning Score (EWS) was used to record patients’ observations and this was accurately completed. When patients’ condition deteriorated or required additional care and support, staff had correctly referred this for medical review in order to provide appropriate care and treatment.

However, two patients on AMU who had presented with concerns relating to their mental health did not have a risk assessment in place to manage their safety. As such, risks to their health and safety had not been identified and managed appropriately. No assessment had been made as to the risk they posed to themselves and whether they required close observation. No advice was sought from the psychiatric liaison team as to how these risks should be managed.

Staff told us that there was no formal risk assessment completed for patients prior to them being seen by the psychiatric liaison team. Most patients were not referred to the liaison team until they were medically fit for discharge, so during the time from admission to being declared medically fit, there was no risk assessment in place for these patients.

Staff used an “information sharing” online form to alert relevant parties to the patient if there were concerns. This included social services and safeguarding teams and there was a comprehensive list of reasons why this form may be used. For example, if a person had substance misuse issues, concerns of abuse, mental health problems and neglect. Staff were able to report concerns that were not on the list if they felt this was necessary.

We looked at 20 patient care records and did not find any in which all of the risk assessments had been fully completed. The trust was using different online systems and some wards were using paper records as well which made it difficult to clearly identify which assessments had been completed. Risk assessments such as nutrition, falls and pressure ulcers were completed on the online record system however we found an example where the risk assessments had been checked as completed but were empty when opened up. We escalated this to the ward manager at the time.

Nursing staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Some staff we spoke with identified where they had not had sufficient staff to meet the safer staffing tool. The service used the safer staffing tool to determine the amount of staff needed. As a result there was a set amount of staff per day.
This arrangement did not take into account where patients required additional support from nursing staff. As a result staffing was based on numbers of patients and not on their specific needs.

Managers informed us of a staffing review which had taken place to address issues across the hospital and re-evaluate nursing establishment levels. No recognised acuity tool was used in this review instead the skills and experience of senior managers was used to determine safe staffing levels.

Staff reported that there had been little improvements since the last inspection in relation to staffing as staff were relocated to other wards to cover for staffing gaps.

Patients with complex needs are often identified as needing enhanced care which is when a member of staff is allocated to observe and care for them on a one to one basis. We found an example on ward F8 (cardiology) where enhanced care had not been provided to a patient who needed it during the day shift due to inadequate staffing levels. On ward F7 (respiratory), patients receiving Non Invasive Ventilation (NIV) which requires enhanced care of one nurse to two patients with NIV were being accepted onto the ward. The matron had informed us that NIV patients were not being accepted due to staffing shortages. There were three qualified nurses per shift including the shift coordinator and the ward manager was available during the week. Staff told us that any shortages in staffing were escalated and that bank staff would be used if needed to meet the needs of patients. Some staff expressed concern that there were not sufficient staff to care for patients with complex needs.

Where there were staffing shortages managers and shift coordinators would often care for patients which prevented them from carrying out their role specific tasks and having good oversight of what was happening across the ward.

The skill mix of staff was also a concern across the hospital. We found instances where newly qualified nursing staff were allocated as shift coordinator and were still required to care for patients. The newly qualified staff we spoke to told us that this was a responsibility they did not feel they had enough experience to undertake and that it caused them additional stress and concern. However, this was an accepted practice at the hospital.

Staff reported that there had been little improvements since the last inspection as staff were relocated to other wards to cover for staffing gaps. There was an ongoing recruitment programme for both nursing and medical staff.

Arrangements for handovers and shift changes ensured that patients were safe as these were done in a room away from the ward activity and were uninterrupted. Handovers took place at each shift change and staff completed a “safety huddle” which consisted of sharing information around incidents and high risk patients.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in medicine for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>443.72</td>
<td>532.88</td>
</tr>
<tr>
<td>January 17</td>
<td>437.43</td>
<td>530.88</td>
</tr>
<tr>
<td>February 17</td>
<td>436.90</td>
<td>531.88</td>
</tr>
<tr>
<td>March 17</td>
<td>443.09</td>
<td>532.48</td>
</tr>
<tr>
<td>April 17</td>
<td>437.23</td>
<td>533.34</td>
</tr>
<tr>
<td>May 17</td>
<td>434.07</td>
<td>544.75</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 16.9% for nursing and midwifery staff in medicine;

- Royal Oldham Hospital: 5.0%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.3% for nursing and midwifery staff in medicine;

- Royal Oldham Hospital: 1.2%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 4.3% for nursing and midwifery staff in medicine, which is in line with the trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 3.4%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

In the RPIR the following medical wards were listed as three of the five wards across the trust with the highest bank or agency use.

- CG316 Acute Medical Unit – Royal Oldham Hospital
- CJ312 Ward E1 – North Manchester General Hospital
- CH316 Ward 21 – Fairfield General Hospital

This high use of vacancy and bank staff on these wards was attributed to high vacancy rates, long term sickness and absence.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Vacancy rates had improved among medical staff since our last inspection. However, staff still reported feeling stretched and over worked. Senior management confirmed that although there were some gaps in medical cover, there were plans in place to combat this issue. At the time of our inspection medical staff were rotered to cover one weekend in eight. Locum staff were recruited to cover gaps in the medical on call rota to ensure that safe care could be provided to patients at all times.

The trust has reported the following planned and actual staffing figures for medical and dental staff working in medicine for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>120.06</td>
<td>131.52</td>
</tr>
</tbody>
</table>
Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.2% for medical and dental staff in medicine;

- Royal Oldham Hospital: 8.3%

(Source: Routine Provider Information Request (RPIR) – P17 Vacancies)

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 2.1% for medical staff in medicine;

- Royal Oldham Hospital: 1.6%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 0.3% for medical staff in medicine which is better than the overall trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 0.4%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average whilst the proportion of junior (foundation year 1-2) staff was slightly higher.

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<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>25%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Records

Staff did not consistently keep appropriate records of patients’ care and treatment.

Intentional rounding is a structured process whereby nurses carry out regular checks with individual patients to address issues of positioning, pain and personal needs. We reviewed 20 patient care records and found that records documenting the frequency and outcomes of intentional rounding were not completed consistently and showed that these checks were not being carried out regularly.

There were a variety of recording formats including two electronic systems and differing paper records. This was a particular issue for staff on the discharge ward where, because records had been completed in a variety of areas, they were not easily read by staff in order that safe support could be provided to patients. Staff told us that the electronic recording system was not difficult to use, but could be time consuming particularly as patients who were transferred to a medical ward from the emergency department were required to have all of their information input onto a different computer system. The system did not allow staff to print out copies of patients’ records to be filed in their paper notes.

However, we also found that Early Warning Scores (EWS) used to record observations and identify signs of deterioration were completed correctly and any reviews from the medical team during ward rounds were clearly documented in patients’ notes.

Records were stored securely in lockable trolleys on the wards. Computer screens were turned away from the view of any visitors or patients passing by and we observed staff locking computers when not in use so that patient identifiable information was not accessible.

Medicines

Although generally medicines were found to be stored correctly and securely, we found one out of four wards where medicines were stored in areas where the temperature had exceeded manufacturers recommendations.

Over the past month, ambient temperatures were recorded as consistently having exceeded 28 degrees and the fridge temperature was recorded as exceeding the maximum eight degrees on a daily basis. Staff were observed propping open the door to the storage room while preparing medications because of the heat. This was an ongoing issue of which staff were aware and staff informed us that storage temperature had been a problem for at least the past six months with no resolution having been found. The majority of the medicines had manufacturers recommendations stating that the medicines were not to be stored above 24 or 25 degrees. As a result the effectiveness of the medications may have been affected by the temperatures they were stored in.

Controlled drugs were stored securely and their use signed for and recorded as per trust policy.

Thickening agents used to aid patients with difficulties swallowing were stored in a locked cabinet when not in use as per current guidelines.

Incidents

Staff recognised incidents and knew how to report them, however there were inconsistencies across the service.

Not all staff considered staff shortages as a reportable incident and we saw one example where a patient required enhanced care which could not be provided due to staffing on the ward. This had not been reported as an incident.
Where incidents had been reported managers investigated incidents quickly, and shared lessons learned and changes in practice with staff through daily safety huddles which took place during handover on the wards. Staff were confident that any changes to practice as a result of learning from incidents would be shared with them.

Managers told us that any immediate learning following an incident would be discussed directly with the individual member of staff involved.

Any unexpected deaths or potentially avoidable deaths that occurred in the department were reviewed and discussed at mortality meetings. This meant any patterns and trends could be reviewed and lessons to maintain safety could be identified. Managers told us that any immediate learning following an incident would be discussed directly with the individual member of staff involved in the form of a debrief.

Staff we spoke to were aware of the statutory duty of candour principles and could provide an example of when this would need to be applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Medicine.

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 41 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017.

![Bar chart showing incident breakdown]

The breakdown of incident types was:

- 14 slips/trips/falls meeting SI criteria (34% of total incidents)
- 11 all other categories (27% of total incidents)
- 6 sub-optimal care of the deteriorating patient meeting SI criteria
- 4 VTE meeting SI criteria
3 treatment delay meeting SI criteria
3 HCAI/Infection control incident meeting SI criteria
(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 41 new pressure ulcers, 29 falls with harm and 24 new catheter urinary tract infections between August 2016 and August 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Pennine Acute Hospitals NHS Trust

Pressure ulcers were recorded for every month during the period aside from June 2017.
Falls were recorded for every month during the period.
C.UTIs were recorded for all months during the period except September 2016 and March 2017.
(Source: Safety thermometer - Safety Thermometer)

Is the service effective?
Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. Managers did not always check to make sure staff followed guidance.

Managers did not review care pathways and plans regularly, such as those for patients with cognitive impairment or at risk of sepsis. Sepsis is a potentially life-threatening condition; however it can be easily treated if identified early. When we spoke to staff they were able to confidently discuss signs of sepsis and management of sepsis in line with guidelines set out by Sepsis UK and we found evidence of these guidelines being followed in patient records.

A frailty scoring system had recently been implemented in the Acute Medical Unit to help identify patients with complex needs who required more support and input from an appointed consultant. A total of 12 beds on the unit had been allocated in which to cohort patients who scored highly so that they could be cared for appropriately. These patients received input from an advanced nurse practitioner who specialises in frailty. Since these measures had been implemented the average length of stay of patients has reduced at the unit and staff working on medical wards have noticed a reduction in readmissions of patients with complex needs.

The Acute Medical Unit had also taken the step to remove commodes from the unit as part of the End PJ Paralysis campaign. End PJ Paralysis is a national campaign which encourages hospital patients, where appropriate, to dress in their own clothes and mobilise as much as possible in attempt to aid recovery. The removal of commodes from the unit encourages patients to mobilise to the toilet if they are able to do so. The falls team at the hospital had raised concerns that this change might result in an increase in falls but these concerns have not been realised.

The hospital had a bundle in place for patients with Acute Kidney Injury (AKI) however the medical staff we spoke to were not aware of this. We saw no evidence of care plans being completed for those with AKI and specialist input for this group of patients was poorly documented. Medical staff informed us that a nephrologist would visit patients with AKI admitted to a medical ward once a week. We were not assured that the hospital was following clinical guidelines based on best available evidence in order to care for patients with AKI. When asked, clinical leads were uncertain of any audits which monitored the outcomes of patients with AKI and they were not aware of who the lead specialist was for this area.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. There was assurance of nutritional assessment as it was monitored through the nursing assessment and accreditation scheme.

Patients told us that they had access to food and drink on request and that there was a good selection of meals available. Meals were available which catered to people’s cultural and religious needs and preferences. However, patients’ diet and fluids were not effectively monitored in order to make sure they had sufficient food and drink.

Throughout the service we found that fluid balance charts which monitor a patient’s fluid intake and output were not completed consistently. Often there were gaps in the documentation of these charts which caused difficulty in monitoring a patient’s nutrition and hydration.

Pain relief

The management of pain for patients was not consistently monitored. Pain scores for patients were inconsistently recorded or monitored.

This was particularly noted for patients with a cognitive impairment where the assessment of pain is more complex. There were no arrangements in place that assisted staff to identify patients with cognitive impairment or complex needs in order to identify their levels of pain and address this accordingly. Staff informed us that there was a tool that involved family members but this was not always correctly utilised.
We spoke with eight patients who told us that staff were quick to respond to requests for pain relief when needed.

**Patient outcomes**

Information about the outcomes of patients’ care and treatment was routinely collected and compared against national data.

Patient outcomes measures include; Hospital Standardised Mortality Ratio (HSMR), infection rates, never events, length of stay, hospital acquired pressure ulcers and incidence of falls.

The trust told us that measures to improve patient outcomes are monitored on a monthly basis via mortality and morbidity and divisional governance meetings. These meetings then report into the care organisation Performance and Risk Assurance Group held monthly, and this reports into the Pennine assurance committees and Group Risk and Assurance Committee. A specially-convened morbidity and mortality meeting receives advice and input from a nationally-recognised surgery clinical leader.

Pressure ulcers, falls and rates of infection were also monitored. Information on performance in areas such as falls, pressure ulcers and infections was displayed on a board outside each ward in order to inform the public. However, we looked at these boards and found the information was not always easy to read and understand due to the way they were completed. The service had been outliers’ i.e. worse results than expected for pressure ulcers and falls. However these results had improved over the last few months and the service had action plans in place to monitor these further.

Additionally the Nursing Assessment and Accreditation System (NAAS) had been implemented. The system measures the quality of nursing care delivered by individuals and teams, it incorporates Essence of Care standards, key clinical indicators and each question is linked to Compassionate Care. Since its implementation the service identified that a number of wards previously rated as red (failing in a number of areas) have improved with some now rated as green (good).

We spoke with management regarding the 2016 Lung Cancer Audit and their performance in relation to access to chemotherapy, which was significantly worse than the national average. This was recognised by the service and was seen as a priority in the future. The management was confident that since their previous results this had improved.

Results of the Myocardial Ischaemia National Audit Programme (MINAP) had significantly improved since our last inspection as detailed below.

### Relative risk of readmission

**Trust Level: Elective Admissions**

Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Clinical Haematology and General Medicine patients had a lower than expected risk of readmission for elective admissions.
- Gastroenterology patients had a higher than expected risk of readmission for elective admissions.
admissions.

**Trust Level: Non-Elective Admissions**

Between May 2016 and April 2017;

- All patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- General Medicine patients had a similar to expected risk of readmission for non-elective admissions.
- Infectious Diseases patients had a higher than expected risk of readmission for non-elective admissions.
- Cardiology patients had a lower than expected risk of readmission for non-elective admissions.

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

*(Source: HES - Readmissions (01/05/2016 - 30/04/2017))*

**Royal Oldham Hospital: Elective Admissions**

Between May 2016 and April 2017;

- All patients at the Royal Oldham Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Clinical Haematology patients had a lower than expected risk of readmission for elective admissions.
- Gastroenterology and General Medicine patients had a higher than expected risk of readmission for elective admissions.

**Royal Oldham Hospital: Non-Elective Admissions**

Between May 2016 and April 2017;
- All patients at the Royal Oldham Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General Medicine and Cardiology patients had a higher than expected risk of readmission for non-elective admissions.
- Clinical Haematology patients had a lower than expected risk of readmission for non-elective admissions.

**Heart Failure Audit**

**In-hospital Care Scores**

In the 2015 Heart Failure Audit the trust’s performance in relation to in-hospital care was as follows:

- Royal Oldham Hospital was worse than the England and Wales average for all of the four of the standards relating to in-hospital care.

<table>
<thead>
<tr>
<th>In hospital care – England and Wales averages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology inpatient</td>
<td>48.1%</td>
</tr>
<tr>
<td>Input from consultant cardiologist</td>
<td>58.6%</td>
</tr>
<tr>
<td>Input from specialist</td>
<td>79.9%</td>
</tr>
<tr>
<td>Received echo</td>
<td>91.7%</td>
</tr>
</tbody>
</table>

**Discharge Scores**

In the 2015 Heart Failure Audit the trust’s performance in relation to discharge was as follows:

- Royal Oldham Hospital was better than the England and Wales average for six of the seven standards relating to discharge, but worse for referral to cardiology follow up.
Discharge scores – England and Wales averages

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<thead>
<tr>
<th>Metric</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI on discharge</td>
<td>72.2%</td>
</tr>
<tr>
<td>ACEI/ARB on discharge</td>
<td>83.6%</td>
</tr>
<tr>
<td>Beta blocker on discharge</td>
<td>85.7%</td>
</tr>
<tr>
<td>Received discharge planning</td>
<td>87%</td>
</tr>
<tr>
<td>Referral to cardiology follow-up</td>
<td>52.2%</td>
</tr>
<tr>
<td>Referral to HF liaison service</td>
<td>57.9%</td>
</tr>
<tr>
<td>Referral to HF liaison service (LSVD only)</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

*(SOURCE: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)*

**National Diabetes Inpatient Audit**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 62 inpatients with diabetes at Royal Oldham Hospital, 85.1% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 3.

*(Source: NHS Digital)*

**Myocardial Ischaemia National Audit Project (MINAP)**
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

Between April 2014 and March 2015, 8.6% of nSTEMI patients were admitted to a cardiac unit or ward at Royal Oldham Hospital and 96.6% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%.

The proportion of nSTEMI patients who were referred for or had angiography at Royal Oldham Hospital was 84.9% compared to an England average of 79%.

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>nSTEMI patients seen by a cardiologist or a member of team</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>433</td>
</tr>
<tr>
<td></td>
<td>88.9%</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>385</td>
</tr>
<tr>
<td></td>
<td>96.6%</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
</tr>
<tr>
<td></td>
<td>95.1%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 77%, which was worse than the audit minimum standard of 90%. The 2015 figure was 92%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25.5%; this is not significantly different from the national level. The 2015 figure was 27%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 57.4%, this is significantly worse than the national level. The 2015 figure was 51%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64.9%, this is significantly worse than the national level. The 2015 figure was 70%.

The one year relative survival rate for the trust in 2016 is 34.1%, this is worse than the national aggregate.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust did not take part in the 2015 Audit of Inpatient Falls.

(Source: Royal College of Physicians)

Competent staff

Staff had their learning needs identified and assessed during their annual appraisal however appraisal rates were low indicating that appraisals did not always take place on an annual basis. Staff told us that the appraisal process was valuable and provided opportunity for them to discuss their personal aims as well as mandatory training.
However, staff did not always receive the specialist training they needed as part of their roles. As an example, staff on ward F8 (cardiology) and the coronary care unit had not received training or had their competencies assessed in the use of continuous cardiac monitoring (telemetry) in order to maintain patient safety. Staff told us that informal training took place peer to peer, but this did not adequately assure that staff had the correct skills in order to carry out this part of their role.

In an attempt to drive improvement and build the skills of staff, ward F7 (respiratory) had allocated a specialism for each nurse to undertake a link nurse role. As a link nurse, the staff member would attend training relevant to their allocated specialism and feedback to other staff members as well as providing support and advice around their specialism. One staff member we spoke to was excited to take on this role, but had not had opportunity to attend any specific training events; this was raised at their most recent appraisal, but as at the time of the inspection they were not booked onto any training sessions.

Medical and nursing staff were supported through the revalidation process. Revalidation is the new process that all nurses and midwives in the UK need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing. Medical staff also undergo revalidation to maintain their registration with the General Medical Council (GMC). This has been in place since 2012.

**Appraisal rates**

Between June 2016 and May 2017, 55% of staff working within medicine at the trust had received an appraisal compared to a trust target of 90%.

The 55% appraisal rate applies to nursing and midwifery registered, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Royal Oldham Hospital 55% had received an appraisal.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Multi-disciplinary team meetings were held daily in order that plans could be in place to deliver the most effective treatment to patients. Input from dietitians, physiotherapists and social workers was clearly documented in patient records. Nursing staff told us they had built good working relationships with medical staff in order to provide effective care and treatment to patients.

However, nurse staff on ward F7 (respiratory) did not have access to the medical staffing rota and this impacted upon planning of care for patients. Staff were not informed of gaps in the medical rota and told us that meant they were unable to reliably tell patients and relatives of when a doctor would come to review their care.

During focus groups we found that Allied Health Professionals (AHPs) often felt overlooked. This was something the trust managers were aware of and had put a plan in place to create Care Organisation AHP leads.

**Seven-day services**

Services were planned so that patients could access the care and treatment they needed at all times.
Specialist medical teams such as cardiology were available for advice at weekends however staff told us that there were difficulties in accessing specialists for a face to face review of patients.

Emergency endoscopy was available 24 hours a day to manage gastrointestinal bleeding; this service was recently implemented and medical staff had to be removed from the general medical on call rota to fill the emergency endoscopy cover.

The psychiatric liaison service was available 24 hours a day.

Occupational therapy services were available at weekends, although this could be limited to mornings only.

Physiotherapy was provided at weekends for patients with respiratory problems which could assist with patients discharge from the hospital.

**Health Promotion**

Public health leaflets and posters were displayed throughout the hospital advertising services such as smoking cessation.

Patients and relatives were informed of how best to maintain their health following discharge via the discharge lounge. This practice helped to prevent readmissions.

During our inspection, we observed that all staff and visitors were offered a flu vaccine free of charge.

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

The arrangements for patients’ rights to be protected under the Mental Health Act 1983 and the Mental Capacity Act 2005 were not effective. Records recording capacity assessments were not always completed accurately or with sufficient detail. Discussions with patients’ relatives or advocates were not always undertaken in order to fully explore the patients’ best interests and obtain a valid consent.

Of the 20 records we looked at, we found some examples where capacity had been assessed thoroughly and decisions made appropriately in accordance with the relevant legislation. However, we found three examples of DNACPR forms which had been partially or incorrectly completed. Reasons stated for DNACPR were listed as frailty and dementia and discussions surrounding the decision for DNACPR were not recorded.

The use of deprivation of liberty safeguarding order (DoLS) for patients who lacked the capacity to consent to treatment and were required to remain in the hospital were appropriately applied for and correctly implemented.

**Mental Capacity Act and Deprivation of Liberty training completion**

Data for this metric was not provided.

(Source: Trust Routine Provider Information Return (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

Patients and relatives we spoke with gave positive feedback about the care and support they received from staff and praised them for their kindness.
Staff demonstrated that they were aware of and responded to people’s individual needs, backgrounds and spiritual needs. This assisted staff to provide individualised care to the person.

We observed staff interacting with patients with compassion and treating them with respect.

We were told of an instance when staff on ward G1 (discharge lounge) had responded with compassion. The relative of a patient had commented that their birthday was coming up and that they had not received any flowers from the patient in a long while due to their medical condition. The members of staff then decided to buy a bouquet of flowers using their own money on behalf of the patient and gave them to the relative.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Staff responded compassionately when people needed help and supported them to meet their basic personal needs when required.

While staff were aware of the impact a person’s condition or treatment might have on their emotional wellbeing, they were not always aware of additional services or therapies which could be offered to patients with life changing conditions. As such patients and their families were not informed of how to access additional support outside of the hospital.

Patients told us that staff were quick to respond if they became distressed or upset and did so in an understanding and empathetic way.

On most of the wards we visited there was a quiet room which relatives could use if needed. A chaplaincy and spiritual care team was available to patients and relatives at all times and could offer emotional support as well as religious care. A Christian chapel was available during the daytime and a Muslim prayer room with a women’s area is open 24 hours a day.

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

We saw some evidence in patients records of discussions with relatives, although this was not always evident. What information had been given to patients regarding their care and treatment was not always clear from records and on speaking to patients and relatives there remained inconsistencies in how much they were involved in decision making regarding care and treatment.

One relative told us they had been given conflicting views and advice on discussion with various members of staff and were unclear as to the plan of care for the patient. When we reviewed the patients’ records there were no documented discussions with relatives regarding a plan of care and no clear plan had been set prior to transfer to the ward. We spoke with the ward manager who was already aware of the situation and all issues were resolved quickly.

**Friends and Family test performance**

Between August 2016 and July 2017 the Friends and Family Test response rate for Medicine at the trust was 22% which was slightly worse than the England average of 25%.
A breakdown of percentage recommended by site and ward is shown below:

<table>
<thead>
<tr>
<th>Site – level</th>
<th>Trust – level</th>
<th>National – level</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

(Source: NHS England Friends and Family Test)

Is the service responsive?

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

The service did not consistently plan and provide services in a way that met the needs of local people.

The environment throughout the service was not sufficiently adapted to assist people with complex needs or cognitive impairment to easily deliver care in a way that met their needs and promoted equality. Throughout the service the signage was confusing with many of the medical wards identified by different names than the ward was known as. This was also reflected in the service’s website which identified wards by different names. This made navigating throughout the service and between different wards difficult.

Ward G1 (discharge lounge) had made a number of adaptations to meet the complex needs of patients. This included pictures on the walls of old Oldham, a dementia garden and the development of dementia boxes which contained pictures that staff could use for discussion and
social interaction with patients. However, the ward was undergoing redesign which resulted in a reduction to the size of the discharge lounge and more inpatient beds had been introduced. This meant that the room allocated as the discharge lounge now appeared more clinical than previously and there was a lack of stimulus for patients waiting for transport or medications. Staff told us that they had not been part of the decision making with regards to these changes.

The hospital and clinical areas were accessible by wheelchair and accessible toilets were located on wards and throughout the hospital.

The hospital was part of the Greater Manchester health and social care devolution programme to provide a partnership approach to care and the healthier together programme. The programme aimed to help meet the needs of the local population by forming more specialised services.

Average length of stay

Trust Level: Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all elective patients at the trust was 5.1 days, which is higher than the England average of 4.2 days.
- Average length of stay for Gastroenterology and General Medicine elective patients is lower than the England average.
- Average length of stay for Clinical Haematology elective patients is higher than the England average.

Trust Level: Non-Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at the trust was 5.0 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine and Infectious diseases non-elective patients is lower than the England average.
- Average length of stay for Cardiology non-elective patients is higher than the England average.

Royal Oldham Hospital: Elective Average Length of Stay
Between June 2016 and May 2017;

- The average length of stay for all elective patients at Royal Oldham Hospital was 5.1 days, which is higher than the England average of 4.2 days.
- Average length of stay for General Medicine and Gastroenterology elective patients is lower than the England average.
- Average length of stay for Clinical haematology elective patients is higher than the England average.

Royal Oldham Hospital: Non-Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at Royal Oldham Hospital was 5.4 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine non-elective patients is lower than the England average.
- Average length of stay for Cardiology and Clinical haematology non-elective patients is higher than the England average.

(Source: Hospital Episode Statistics, RPIR – Sites Acute Tab)

Meeting people’s individual needs

Patients with complex needs such as a learning disability, dementia or a mental health needs were not easily identified in order for staff to provide additional person centred support. Staff showed us that alerts could be put onto the online records system, but these were not immediately apparent and staff were required to actively check for alerts. We saw evidence in patient records of input from social workers and support staff where alerts had been identified.

The most requested languages for written information were Urdu, Punjabi, Bangla and Polish. Staff told us they had access to face to face interpreters if required. However, they also stated that they had rarely used this facility as family often acted informally as interpreters. This is not best practice as family translations may not be suitable.
We observed two nursing handovers at Royal Oldham in which the information given was centred on patients’ health conditions. Discussion around patient choices and preferences was inconsistent. In one handover this was taken into account and considerations around provision of care were person-centred but this was not reflected in another handover observed suggesting that people’s individual needs are not consistently considered across the trust.

The Rapid Assessment, Intervention and Discharge (RAID) service was available 24 hours a day, seven days a week and provided services to patients who were not known to mental health services, but required an assessment of their mental health or additional input. We saw evidence of the RAID team being used effectively to put plans in place and reduce the length of stay of patients with more complex needs.

Access and flow

There was an escalation policy in place for use in times of additional pressure on the service. Staff were able to explain how they would escalate issues surrounding capacity to managers and managers told us that these issues were discussed at bed meetings which took place three times a day. Bed meetings provided opportunity for managers to locate available beds for patients who required admittance to the hospital and initiate the escalation policy if necessary to do so.

Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).

Medical outliers were cared for by a dedicated consultant and junior doctor team. Daily ward rounds were held for outliers. We saw that on every ward we attended there was a minimum of one patient who was not situated in a bed better suited to their needs.

A discharge lounge was in place on ward G1 where patients could wait for take home medications and transport home during daytime hours. This meant that patients were not waiting on the wards in beds unnecessarily. During our inspection, we observed the discharge lounge in use and staff there told us this was well used.

We found that patients were delayed from discharge due to medicines or ambulances not being available. This was particularly evident at weekends when pharmacy provision was not available after 12 midday Saturday causing delays to patients who needed to have their medicines prior to being discharged.

Some wards had prioritised prescription of take home medicines at the weekend, so that these could be dispensed prior to pharmacy closing, however this was not always possible. Staff told us that the online medicines system did not allow for prescription of take home medicines until the decision to discharge the patient had been made which prevented this from being done in advance.

Referral to treatment (percentage within 18 weeks) - admitted performance

Between August 2016 and July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine has remained fairly consistent and has been in line with or better than the England average for 10 of the 12 months in the period (September 2016 and February 2017 slightly below the England average).

As of July 2017 98% of patients were treated within 18 weeks compared to the England average of 90%.
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Medicine broken down by specialty is below. Of these, four of the specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.2%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moves per admission

As detailed below, we found evidence that patients were moved several times during their stay in hospital and on occasions this could be overnight. This was confirmed during the inspection as we saw that at least three people with a diagnosis of dementia were moved late at night and early in the morning. One patient we spoke to had been moved to another ward at 2am without explanation and described waking up disoriented the next morning.

Information needed to transfer patients between wards or out of the hospital was not consistently completed, accurate or up to date and occasionally it was not available at all. This impacted on the ability of staff to effectively transfer patients to more appropriate wards within the hospital when required.

Between June 2016 and May 2017, overall at the trust, 60% of individuals did not move wards during their admission, and 40% moved once or more.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of individuals not moving wards</th>
<th>% of individuals with one or more ward moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Manchester General Hospital</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Rochdale Infirmary</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Return – Bed Moves)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

There had been a reduction in the number of complaints received since our last inspection.
Formal complaints were raised through the Patient Advice and Liaison Service (PALS) and information on how to contact PALS was displayed throughout the hospital. Further information and the trust complaints handling policy was available to the public via the trust website.

Complaints were investigated and completed in a timely way with the learning discussed and changes to the service provided influenced by the findings of the complaints.

The hospital had seen a fall in the number of complaints since the last inspection. Management confirmed that there were no complaints which had not been addressed within the timescales outlined by the service. Staff knew how to deal with complaints and concerns which were investigated by managers who shared lessons with all staff.

Staff were able to describe Duty of Candour and could give examples of when they would need to implement this.

Patients and relatives told us they felt confident to raise any concerns and their opinions would be listened to.

**Summary of complaints**

Between June 2016 and May 2017 there were 166 complaints about Medicine (20.4% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 here were 52 complaints still open and yet to be completed.

There were 39 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 23%.

Royal Oldham Hospital: There were 59 complaints (35.5%)

There was one complaint relating to all sites.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run the service.

Since our last inspection the trust had restructured to form Care Organisations which covered each location; this enabled leaders to have clearer oversight of their respective services. The clinical leaders we spoke with were positive about the changes to management structures and the move to Care Organisations, but accepted that this model of working was still in its infancy.

Ward staff were not always aware of who their clinical lead was within the Care Organisation, but the majority of staff were aware of changes that had been made to the leadership structure. Staff told us that they felt positive about the changes made, although felt that there had been a lot of changes all made at once.

The directors and clinical leads that we met with were passionate and enthusiastic about their roles, as well as being aware of the challenges to improvement and looking at ways to overcome them.

**Vision and Strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action. This was developed with involvement from staff, patients and key groups representing the local community. Staff showed an awareness of the trust vision and what steps were being taken to achieve this.
The strategy had been developed through engagement sessions with staff. There had been three separate days of staff engagement and 1000 voice events. Staff we spoke with were aware of the vision and strategy for the division and the care organisation.

The services vision is to be ‘A leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.’

The trust outlined its values as; quality driven, responsible and compassionate. Corporate priorities were outlined on the Trust website as; quality improvement, sustainability, integration and compliance with mandatory standards.

Throughout the service we saw posters outlining the vision and strategy and the progress the service was making to achieve its vision.

The hospital had improved on many of the issues for action highlighted in the previous inspection such as staffing, assessing risks to patients and assessing and monitoring the quality of services provided to patients. There was a clear vision and strategy, that was available throughout the hospital and staff were aware of these.

Since March 2016, Salford Royal NHS Foundation Trust has taken over management of Pennine Acute Trust. The leaders we spoke to were positive about learning which could be taken from Salford Royal NHS Foundation Trust, but were keen to maintain a separate identity.

The trust provided us with a copy of their Quality Improvement Strategy and we were encouraged to see evidence of the projects outlined in strategy being implemented on the wards. Examples of projects included; end pj paralysis, introduction of early warning scores (EWS), reliable ward rounds, venous-thrombo-embolism (VTE) assessments and redesign of the medical admissions unit (MAU) to include frailty.

Culture

A consistent positive culture that supported and valued staff, creating a sense of common purpose based on shared values was not yet in place.

While we found a mostly positive culture throughout the hospital, some staff we spoke with identified that they felt the culture was not supportive. Some staff also felt that they were not given the correct assistance in order to be able to safely complete their duties. Some staff reported that they were undertaking responsibilities beyond their grade and on occasions felt unsupported by managers.

Managers said that there was a wide diversity of staff across the professions and grades of the hospital. However the staff survey results highlighted an inequality in the support and promotion of BME staff. Black and Minority Ethnic (BME) is the terminology normally used in the UK to describe people of non-white descent. A BME staff network has been put into place which was to be mentored by members of the Board of Directors. The senior staff we spoke to were surprised to hear of the survey results in relation to this.

There were processes in place for the application of the duty of candour and for the service to be open and transparent. We saw that in the investigation of incidents the duty of candour had been applied appropriately.

Governance

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The division of medicine had a divisional governance lead. Quality and performance meetings were held within the division and this was in turn fed up to the Trust Executive Quality and Patient
Experience Governance Committee. Divisional governance leads met together to share learning across divisions.

There were three care organisations in the trust; each care organisation had a divisional leadership team comprising of the managing director and supported by the medical director and the director of nursing. There was clear accountability and objectives for the directorate that were set by the director team and the board.

Under the director leadership structure was the site management structure, the general and specialist medicine directorate with a directorate manager and clinical directors. At all levels of management, there were clinicians to support the strategic and operational delivery of services.

This management structure had been in place since January 2017 and there had been an improvement in safety performance, staffing including medical staffing and the standardised hospital mortality rates since. Staff, including consultants said that things had improved since the new management structure, but that there was still work to do. There was a quality dashboard for the hospital which included a number of indicators and targets for safe and responsive care. The dashboard showed previous and current performance and indicated trends of the performance with colour coding for performance. The quality dashboard indicated an improving trend.

The service had implemented a nursing assessment accreditation system. This covered a number of areas including nutrition, tissue viability, falls, medicines, care plans, patient experience and mandatory training. Wards were inspected and graded as red, amber or green. Action plans were put in place as appropriate. Ward managers said that this had improved patient safety on the wards. Staff told us that quality improvement was an agenda item at each of their staff meetings.

Management of risk, issues and performance

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not consistent.

The medical division had risk management and quality measures in place to improve patient care, safety and outcomes. There was a risk register for the service and directors were able to give examples of risks listed as high on the register. They were also able to describe how these risks were being mitigated and how this was being monitored for improvement.

Nursing Assessment and Accreditation System (NAAS) results recognised the need for improvement to patient care and demonstrated that improvement was possible given the current constraints. Many results had improved over time and were rated as good at the time of our inspection.

Senior managers were not always assured that steps taken to mitigate risks to patients had been implemented at ward level. An example of this was that we were informed by directors that patients receiving Non Invasive Ventilation (NIV) were not being cared for on the respiratory ward due to low staffing. When we visited the respiratory ward there were patients receiving NIV.

The National Confederation Enquiry into Patient Outcome and Death report, Inspiring Change, is a review of the quality of care provided to patients receiving acute non-invasive ventilation (2017). This states 'It is recommended that NIV services have “trained and experienced staff available to support the service on a 24/7 basis”. Patients who are treated with acute NIV are seriously ill with complex problems and require enhanced nursing care. A staffing ratio of one nurse to two NIV patients for at least the first 24 hours of treatment is recommended.

Information Management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff and managers confirmed that a secure login was required that was unique to the individual before they could access confidential information. Staff also confirmed that they had been given
guidance on information governance and maintaining the security of the system such as not opening emails that were suspicious.

Staff described the IT systems at the hospital as slow and not fit for purpose. At times when the system was in high demand such as during morning ward rounds, results from tests could take up to an hour to download in order that staff could see the results. Additionally there was a variety of different systems that did not ‘talk’ to each other.

The service had two IT outages in the last 12 months. There were emergency plans in place which senior management stated had worked appropriately and had not had a major impact on the service provided.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust told us that a staff engagement lead was appointed in April 2016. Quarterly pulse check surveys were introduced to provide a regular sense check on how staff were feeling.

Feedback from staff had resulted in the introduction of a number of initiatives to improve engagement. “Go Engage” was a model which had been rolled out throughout the trust, although the staff we spoke to did not mention the initiative when questioned about how they could influence change.

Restructuring to form Care Organisations was intended to encourage engagement at a more local level and we found examples where this had worked in the hospital. Staff working on the respiratory ward were familiar with their directors and found them approachable.

Patients were involved in patient led assessments of the care environment (PLACE) visits and were invited to listening into action focus groups throughout the year.

Response rates to the friends and family test in medicine were 22% which was slightly worse than the England average of 25%. This represented a reduction from previous results.

There were open and honest care boards including “you said, we did” information displayed throughout the service. These boards displayed comments received from patients and planned or actual changes made as a result.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Managers monitored performance and used the results to help improve care. These systems were not yet fully implemented and had not identified all concerns noted at this inspection, such as lack of appropriate record keeping and staffing levels to meet patients’ needs.

The hospital were following the guidance from the National Quality Board learning from deaths. The frequency of mortality meetings had improved and there was a meeting every month instead of every two months. Previously each speciality was discussed in turn but cases were discussed as they arose.

The structure of the meetings had changed and there were joint meetings with urgent and emergency care with a focus on patient care in the first 24 hours and was reflective of the patient journey. Minutes were shared for more joined up learning and shared across the specialities. There was also sharing of information about patients’ pre-critical care.

There had been a multidisciplinary review of mortality and morbidity which included representation from senior allied health professionals, junior doctors, assistant directors, consultants, GP’s with links into community services and families via the bereavement nurse.
A deteriorating patient collaborative was set up which was formed of expert nurses, doctors and specialists to improve detection of deterioration in a patient’s condition across the hospital. The collaborative met monthly and had introduced an online observation record to be piloted at Fairfield Hospital.

There was facilitated teaching in forums, e.g. mortality matters in foundation teaching by the mortality lead. The end of life team did teaching sessions in acute medicine and for medical staff. There were also teaching sessions by the coroner and a presentation by family regarding resuscitation decisions and discussions.

Managers encouraged innovation and shared good practice upwards so other divisions could benefit. Examples included students supported to develop leadership skills and training of pharmacy staff to administer medicines freeing up staff to supply care and treatment.
### Surgery

#### Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all trust services).

The Royal Oldham Hospital provides general surgery, orthopaedic trauma, vascular, general surgery and gastroenterology.

There is also an Endoscopy Unit and a Surgical Admissions Unit.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

There were 3,382 day case surgical admissions, 2,262 elective surgery admissions and 7,257 non-elective surgery admissions between July 2016 and June 2017.

(Source: HES data)

The trust had 54,841 surgical admissions between June 2016 and May 2017. Emergency admissions accounted for 15,857 (28.9%) admissions, 30,265 (55.2%) were day case and the remaining 8,719 (15.9%) were elective.

(Source: CQC Insight)

#### Is the service safe?

##### Mandatory training

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Surgery & Anaesthesia Division are shown below:

Medical and dental staff in the Surgery & Anaesthesia division met the 90% target for mandatory training compliance for two modules only (advanced paediatric life support (100%) and advanced life support (91%)).

Basic life support training had the lowest compliance levels with only 59% of eligible medical and dental staff having been trained.
Nursing and midwifery staff in the Surgery & Anaesthesia division met the 90% target for mandatory training compliance in four modules, achieving 100% compliance in three (advanced life support, paediatric immediate life support and moving and handling (non-patients)). Immediate life support training had the lowest compliance levels with only 31% of eligible nursing and midwifery staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff in theatre had not received advanced life support training as recommended in national guidance.

There was no evidence that staff who worked in the recovery area of theatre had received training in adult life support. This is not in line with national guidance by the Association of Anaesthetists in Great Britain and Ireland (AAGBI 2013).

Staff confirmed that they received induction and mandatory training specific to their role.

Staff we spoke with told us that basic life support had been completed rather than immediate or advanced life support. This was appropriate for ward-based nurses.

Following the inspection, we were told that on average 69% of surgical staff had received training in sepsis six, although this ranged from 13% (vascular medical staff) to 100% across wards.

Compliance rates for other mandatory training was provided:

- Workplace induction 93%
- Equality and Human Rights tier one 91%
- Equality and Human Rights tier two 87%
- Fire awareness 86%
- Health, safety and welfare level one 90%
- Moving and handling non-patient 91%
- Moving and handling patient 81%
- Basic adult life support 80%
- Basic paediatric life support 88%
- Immediate life support 7%
- One staff member had completed advanced life support
- Three staff members had completed advanced paediatric life support
- One staff member had completed advanced trauma life support

**Major incident awareness and training**

The service planned for emergencies and staff we spoke with explained their roles if one should happen.

There was a site-specific trust major incident plan

Some staff we spoke to had been involved in a major incident earlier this year and told us the plan worked well.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in the division of Surgery and Anaesthesia is shown below:

![Safeguarding training completion by module](chart.png)

The 90% target was only met for one of the safeguarding modules (level 2 adults) by medical and dental staff in the Surgery & Anaesthesia division at the trust. The target for level 2 children’s training compliance was almost achieved with 87.4% compliance which equated to 311 of the 356 eligible staff members completing the training.

Compliance for level 3 adults was the lowest, with only 161 of the 210 eligible staff members completing the training.
Nursing and midwifery staff in the Surgery & Anaesthesia division exceeded the 90% completion target for both level 2 adults and children’s safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Trust Provider Information Request P18)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had safeguarding policies and procedures in place and there was a safeguarding lead that could provide guidance and support to staff in all areas.

Staff we spoke with understood who to refer a concern to and notice boards displayed contact details of safeguarding or specialist leads.

Safeguarding training formed part of the trust’s mandatory training programme. The service cared for adults only; therefore compliance with safeguarding level two was appropriate.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All ward and theatre areas inspected were visibly clean and cleaning rotas were in place. Staff were observed adhering to ‘arms bare below the elbows’ guidance and washing hands prior to patient contact.

Patients awaiting surgery were screened for infections, such as methicillin-resistant staphylococcus aureus (MRSA), during pre-operative assessments.

There were wall-mounted hand washing solutions at clinical sinks with handwashing instructions. Hand gels and personal protective equipment (PPE), such as gloves and aprons, were adequately stocked in all areas.

Staff were aware of, and adhered to, current infection prevention and control guidelines, such as the ‘arms bare below the elbow’ policy. We observed staff using appropriate hand washing techniques and PPE, such as gloves and aprons, whilst delivering care.

Staff followed the correct dress code and gowning procedures in theatre areas.

The privacy curtains in the bays were not dated. When staff were asked, they did not know how
often they were changed, although if there was an infection risk, they were changed at that time.

All sharps bins seen on the wards were labelled and not over filled, however; two sharps bins were not dated in theatre, with one full; this was addressed when we raised it.

A reusable sigmoidoscopic handle instrument was identified in theatre, rather than disposable; we raised this and the instrument was removed.

Display boards were made of felt material that was difficult to clean.

There were no surgical site audits trustwide; although a surgical site surveillance nurse has now been recruited to monitor infections. The trust reported that between October 2016 and June 2017, there were five infections following repair of fractured neck of femur operations. We were told that this had resulted in full-time surveillance for orthopaedics (hips and knees) and the trust was working with the vascular teams to undertake vascular surgical site infection (SSI) surveillance starting in January 2018.

Staff completed clinical waste segregation (compliance 93%), hand hygiene (compliance 92%), infection prevention non-patient (compliance 91%), infection prevention patient (compliance 81%) and waste management (compliance 94%) as part of mandatory training requirements.

Systems were in place for the inspection and cleaning of theatre ventilation systems. A sample provided showed that these took place annually; fans were cleaned, disinfected and airflow systems calibrated.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The wards and theatres we visited were well maintained, free from clutter and suitable for treating surgical patients.

Entry to some wards and theatre areas was via a controlled access system, in order to monitor staff, patients and visitors.

Processes were in place to maintain equipment, although there was a lack of consistency with labelling of equipment. As a result, it was unclear how ward staff could be assured that the equipment had been serviced or electrically tested, for example, monitoring equipment was labelled with electrical testing stickers to show that tests had taken place within the last 12 months, however; the computer stations were not clearly marked.

Records indicated that staff carried out regular checks on key pieces of emergency, for example, resuscitation equipment had a cursory check completed daily and a more detailed check completed weekly, in line with hospital policy. Ward managers checked on a weekly basis that all checks had been completed. Emergency equipment on resuscitation trolleys were secured with a plastic tamper tag to avoid them being tampered with.

It was noted that fridges temperatures had been recorded outside the recommended range on ward T5. Room temperatures where medicines were stored were recorded daily and these were higher than the recommended limits on ward T5.

Bariatric equipment, which was used for obese patients, was in place and readily available if required.

Most areas that we visited had secure areas, with key pad access, for the storage of hazardous materials or equipment. We found that equipment and material was generally stored appropriately, however, the sluice rooms were not locked and contained hazardous cleaning fluids.

Assessing and responding to patient risk

The World Health Organization (WHO) checklist five steps to safer surgery were not applied
appropriately, as staff did not always verbalise checks.

As part of the inspection, we observed theatre teams undertaking the ‘five steps to safer surgery’, which included the use of the WHO checklist. The WHO Checklist had been re-launched in August 2017. Between April 2016 and June 2017, the service reported between 99% and 100% compliance with the completion of the WHO checklist.

The trust policy for checking of swabs, sharps and instruments in theatres included that a verbal acknowledgement should be received from the operating surgeon in order to prevent any misunderstanding at the final count. It was observed, however, that staff were not verbally checking as per policy and as per the five steps to safer surgery guidance. In May 2017, a trustwide audit of the five steps to surgery (included paediatrics) showed that there was 95% compliance with ‘sign in’, 76% with ‘time out’ and 85% with ‘sign out’.

During the inspection we noted that theatre lists were changed, including on the day of surgery. Patients were often prioritised due to clinical, need which led to a change in the order of patients on the lists. Whilst we understood the need for the prioritisation, we were concerned that this practice could lead to errors if there were multiple changes to a list, as well as patients being nil by mouth for extended periods of time prior to surgery.

Senior managers told us that there had not been any audit of National Safety Standards for Invasive Procedures or Local Safety Standards for Invasive Procedures (NatSSIPS and LocSSIPs). In addition, the trust did not train staff in human factors.

Staff knew how to highlight and escalate risks that could affect patient safety, such as staffing. Matrons and ward managers monitored and dealt with these risks on a daily basis through the matron’s ‘bed meetings’, which took place daily.

On admission to surgical wards, staff carried out risk assessments to identify specific risks, such as venous thromboembolism (VTE), pressure ulcers, fall safe, sepsis six and Malnutrition Universal Screening Tool (MUST). If a risk was identified, the relevant care pathway was implemented.

An early warning score system was in use in all surgical areas. The trust implemented the national early warning score (NEWS), which is a system to identify the early signs of a patient’s condition deteriorating.

Critical care outreach nurses visited the wards daily to support patients and staff that were at risk of deteriorating or had been discharged to the ward.

Outlying patients is a process by which patients are relocated to a ward which is not the most suitable location for their condition, in order to improve patient flow. It is important that these patients receive regular senior medical review to ensure that they are receiving the appropriate, specialist care that they require. Staff told us that all patients received daily review by a specialist consultant and that they received adequate and timely care throughout their inpatient stay.

Following the inspection, we were told that the trust policy for “Correct patient, procedure and site surgery” was to be reviewed, to ensure wording for the entire team in theatre was accurate.

**Nurse staffing**

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Surgical services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE in post</td>
<td>WTE planned</td>
</tr>
<tr>
<td>December 16</td>
<td>602.14</td>
<td>661.36</td>
</tr>
<tr>
<td>January 17</td>
<td>602.18</td>
<td>659.63</td>
</tr>
</tbody>
</table>
Royal Oldham Hospital

The trust has reported the following safe staffing figures for nursing and midwifery registered and unregistered staff working in the surgical services for the period April 2016 to September 2017.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Day Ward Average fill rate - registered nurses</th>
<th>Night Ward Average fill rate - registered nurses</th>
<th>Day Ward Average fill rate - care staff</th>
<th>Night Ward Average fill rate - care staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>T3</td>
<td>83.33%</td>
<td>89.53%</td>
<td>114.44%</td>
<td>122.22%</td>
</tr>
<tr>
<td>T4 (STU)</td>
<td>92.72%</td>
<td>97.78%</td>
<td>100.00%</td>
<td>153.85%</td>
</tr>
<tr>
<td>T5</td>
<td>88.62%</td>
<td>83.33%</td>
<td>92.78%</td>
<td>116.67%</td>
</tr>
<tr>
<td>T6</td>
<td>76.00%</td>
<td>75.00%</td>
<td>77.68%</td>
<td>85.71%</td>
</tr>
<tr>
<td>T7</td>
<td>81.86%</td>
<td>95.51%</td>
<td>116.43%</td>
<td>117.92%</td>
</tr>
</tbody>
</table>

(Source: Committee in Common Scorecard 30 October 2017)

There were processes in place to ensure sufficient numbers of trained nursing and support staff in ward areas and theatres, to provide safe care and treatment. However, the service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment as above.

Open and honest noticeboards with the expected and actual staffing numbers were displayed in all ward areas inspected. Staffing levels were adequate in areas visited at time of inspection with the support of bank and agency.

The trust monitored staffing levels; however, this did not include the use of an acuity tool.

We reviewed the safe staffing figures issued in the Group Committees in Common meeting in October 2017. All surgical wards average fill rates for registered nurse were lower than the safe target during the day and for some at night. Fill rates for health care staff were generally better, particularly at night.

Any shortfalls in nurse staffing were addressed with staff working overtime or with bank or agency staff. Matrons held a daily bed meeting at 11am, attended by all ward managers or their deputies, to discuss staffing. Ward Managers attended with a full week’s off duty to each meeting, to ensure that any staffing risks were highlighted early. Following discussion at this meeting, any areas of concern were highlighted and staff were asked to redeploy to support other areas.

There was also a bleep holder for surgery to address any immediate staffing concerns during the day. We were told that each Friday, matrons reviewed staffing for the weekend to ensure that any risks were identified early.

In theatres, staffing numbers were in line with the Association of Perioperative practitioners
(AfPP) guidelines to ensure the presence of two scrub practitioners, one anaesthetic practitioner, one health care assistant circulating nurse and one recovery nurse.

Detailed patient handovers and safety briefings took place in private offices, however; there were also bedside handovers for staff allocated to those patients. We were told that these bedside handovers were to introduce staff and check documentation, however; information about care was shared that could be overhead by other patients in the bays.

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 8.9% for nursing and midwifery staff in Surgery;

- Royal Oldham Hospital: 7.7%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing and midwifery staff in Surgery;

- Royal Oldham Hospital: 1.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.4% for nursing and midwifery staff in Surgery, which is above the overall trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 5.0%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Medical staffing**

The trust has reported the following planned and actual staffing figures for medical and dental staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>290.65</td>
<td>313.53</td>
</tr>
<tr>
<td>January 17</td>
<td>292.65</td>
<td>316.13</td>
</tr>
<tr>
<td>February 17</td>
<td>296.65</td>
<td>316.18</td>
</tr>
<tr>
<td>March 17</td>
<td>297.65</td>
<td>315.80</td>
</tr>
<tr>
<td>April 17</td>
<td>297.15</td>
<td>315.80</td>
</tr>
<tr>
<td>May 17</td>
<td>293.25</td>
<td>315.80</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**
Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.1% for medical and dental staff in Surgery;

- Royal Oldham Hospital: 6.9%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017 the trust reported an average turnover rate of 1.5% for medical staff in Surgery;

- Royal Oldham Hospital: 1.2%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 1.7% for medical staff in Surgery which is better than the overall trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 1.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Staffing skill mix**

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average whilst the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for whole time equivalent staff working at The Pennine Acute Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>23%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>16%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

There were processes in place to ensure sufficient numbers of trained surgical staff in ward areas and theatres, to provide safe care and treatment.

Doctors we spoke with felt there were sufficient surgical staff for the demands of the division.

We observed a surgical handover. Doctors of all grades attended and we found it to be well-structured, clear and comprehensive. All patients were reviewed thoroughly and appropriately.

Out of hours there were processes in place for consultant cover. For general, colorectal and
vascular surgery, there was a non-resident consultant on call. For trauma and orthopaedics, there was on-site presence between 8am and 6pm at weekends; otherwise there was a non-resident consultant on call.

For gastroenterology there was a consultant rota providing cover (non-resident on call) from 5pm to 9am overnight during weekdays and 9am Saturday to 9am Monday.

Records
Staff kept appropriate records of patients’ care and treatment.

Records were clear, up-to-date and available to all staff providing care. Nursing care records had changed to an electronic system that included a flagging system for any individual need that required consideration.

Patients’ clinical notes were stored in locked trolleys close to the nurse’s stations and were accessed by keypads.

We looked at the care records of 15 patients; these were structured, legible, complete and up to date.

Risk assessments were completed for patients as part of care bundles for surgery.

Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.

Standardised nursing documentation was kept at the end of patients’ beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Staff completed information governance (compliance 90%) as part of mandatory training requirements.

A trust-wide record keeping audit was completed in September 2017. The results found that order of recording was good, however, all other areas required improvement, such as legibility, staff identification and date and time.

Medicines
The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.

An electronic prescribing system was in place. Patient medications were secured either in locked patient cabinets or ward cupboards.

Medicines reconciliation was completed in a timely way by a member of the pharmacy team. We reviewed 16 sets of prescription records. All had been completed within 24 hours of admission in accordance with local and national guidance.

We observed staff undertaking medication rounds appropriately.

Medicines requiring refrigeration were stored securely and maximum and minimum temperatures had been recorded in accordance with national guidance. We checked medicines and equipment for emergency use and found they were readily available and stored appropriately. Staff carried out checks to ensure these were in place and fit for use in accordance with trust policy. We found, however, that fridge temperatures had been recorded outside the recommended range on ward T5. Room temperatures where medicines were stored were recorded daily and these were higher than the recommended limits on ward T5.
In all areas that we visited, medical gases were stored securely with brackets to secure oxygen cylinders in corridor areas.

Discharge medications were managed well, including nurse led discharges, in some areas to encourage timely discharges, particularly when out of hours for pharmacy.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 24 serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 7 slips/trips/falls meeting SI criteria (29% of total incidents).
- 5 all other categories (21% of total incidents).
- 3 surgical/invasive procedure incident meeting SI criteria
- 3 treatment delay meeting SI criteria
- 3 pressure ulcer meeting SI criteria
- 3 sub-optimal care of the deteriorating patient meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

The trustwide electronic reporting system had not been fully embedded with a poor reporting of incidents culture.

The trust used an electronic system to record incidents, however; this system had been implemented in August 2017. Staff could describe the process for reporting incidents and felt confident in doing so; however, some of the staff we spoke with had not reported an incident for a number of years. Staff could request feedback from incidents and they were discussed in monthly team meetings or during daily safety briefings to share and learn lessons from incidents, however, it was not clear if there was cross-site dissemination of lessons learned.

There were a total of 943 incidents reported for the surgical division between August 2017 and October. Of these, the majority were graded as either low or no harm. There were 15 incidents reported as moderate harm, nine graded as near misses, five as severe harm and two deaths.

We reviewed examples of incident investigations; these showed that a root cause analysis had been undertaken, with action plans in place to drive improvement.

Mortality and morbidity reviews were held monthly. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence.

Staff were familiar with the term ‘duty of candour’. The duty of candour is a regulatory duty that
relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person).

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 53 new pressure ulcers, 21 falls with harm and 10 new catheter urinary tract infections between July 2016/17 for Surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Pennine Acute Hospitals NHS Trust**

![Graphs showing the prevalence rate of pressure ulcers, falls, and catheter urinary tract infections](image)

October 2016 saw the highest number of pressure ulcers, falls and C.UTIs recorded during the period. *(Source: NHS Digital)*

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

There were ‘open and honest’ boards in all wards that displayed information about patient safety incidents, such as pressure ulcers, falls and infections, including the date of the last occurrences for each. From the trusts committee in common board meeting (October 2017), the number of
clostridium difficile (C. diff) and pressure ulcers was above their trajectory. Workstreams were in place with site based learning sets for pressure ulcers and infection prevention projects.

The ‘open and honest boards’ information was linked to the values of the organisation.

The surgery wards completed assessments for venous thromboembolism (VTE) as part of preoperative care bundle.

Is the service effective?

Evidence-based care and treatment

In theatres, the service did not always provide care and treatment based on national guidance, for example availability of staff with advanced life support training (ALS) and verbalising the WHO Checklist five steps to safer surgery.

On the wards, the service provided care and treatment based on national guidance and evidence of its effectiveness, such as guidance from the National Institute for Health and Care Excellence (NICE).

Patients that were admitted for colorectal or general surgery had a lower than expected risk of readmission for elective surgery when compared to the England average.

Following the inspection we received an operational policy for the surgical triage unit. We were told that this was under development and not yet ratified.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

We observed staff manage the nutrition and hydration needs of patients well both pre and post operatively.

Patients received letters prior to admission that included instructions about eating and drinking prior to either inpatient or day case surgery. Letters were adapted for operations expected in a morning or an afternoon. A trustwide fasting policy was in place that was in the process of being reviewed and updated.

Staff on the wards used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patients we spoke with told us that they enjoyed the food provided. Wards included trolleys where hot drinks and snacks were available. Water jugs were available for surgery patients able to drink fluids.

The Malnutrition Universal Screening Tool (MUST) was one of the risk assessments in the patient care bundles and completed in all records reviewed.

On ward T5, electronic scales were used to accurately record fluid balance for patients with specialist requirements, such as total parenteral nutrition (TPN)

The trust participated in a diabetes collaborative programme to ensure appropriate nutrition for patients with diabetes, however; we did not see any patients during inspection.

Pain relief

Staff recorded patient pain scores and managed pain well.

Pain scores were recorded, as part of the surgical pathways. We observed nurses checking the comfort levels of patients and saw analgesia administered as needed.
Staff on the surgical wards and in theatres were supported by a specialist pain management team if required.

Patients told us staff gave them pain relief medication when needed.

From the last inspection, the service was not compliant with all the recommendations of the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). A pain standards audit demonstrated some compliance, as well as mitigations, in their action plan, with national guidance including RCoA (2016) and ACSA1. Following the inspection we were told that a Clinical Lead for pain has been appointed.

**Patient outcomes**

**Relative risk of readmission**

For patients admitted for vascular surgery there was a higher than expected risk of readmission.

Patients admitted for general surgery or trauma and orthopaedics had a higher than expected risk of readmission for non-elective admissions when compared to the England average as shown below.

**Trust level: Elective admissions**

![Graph showing relative risk of readmission for elective admissions]

Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology and Colorectal Surgery patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Trust Level: Non-elective admissions**

![Graph showing relative risk of readmission for non-elective admissions]

Between May 2016 and April 2017;
• All patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
• General Surgery, Trauma & Orthopaedics and Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

Royal Oldham Hospital: Elective Admissions

Between May 2016 and April 2017;
• All patients at Royal Oldham Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
• Vascular Surgery patients at Royal Oldham Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
• Colorectal Surgery and General Surgery patients at Royal Oldham Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Royal Oldham Hospital: Non-Elective Admissions

• All patients at Royal Oldham Hospital had a higher than expected risk of readmission for
non-elective admissions when compared to the England average.

- General Surgery, Vascular Surgery and Trauma & Orthopaedics patients at Royal Oldham Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

**Hip Fracture Audit**

The Royal Oldham Hospital:

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.6% which was within the expected range. The 2015 figure was 9.9%.

The proportion of patients having surgery on the day of or day after admission was 64.3% which was worse than the national standard of 85%. The 2015 figure was 66.2%.

The perioperative medical assessment rate was 93.9% which failed to meet the national standard of 100%. The 2015 figure was 93.4%.

The proportion of patients not developing pressure ulcers was 96.9%, which falls in the middle 50% of trusts. The 2015 figure was 97.9%.

The length of stay was 18.4 days which falls in the middle 50% of trusts. The 2015 figure was 19 days.

(Source: CQC Insight - National Hip Fracture Database 2016)

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 79.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 72.7%.

The risk-adjusted 90-day post-operative mortality rate was 7.8% which was worse than expected. The 2015 figure was 5%.

The risk-adjusted 2-year post-operative mortality rate was 24.9% which was within the expected range. The 2015 figure was 22%.

The risk-adjusted 30-day unplanned readmission rate was 9.9% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 58.2% which was worse than expected. The 2015 figure was 61.6%.

(Source: CQC Insight - National Bowel Cancer Audit)

**National Vascular Registry**

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.3% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2015 figure was 2.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 10 days, which was better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 1.6% which was within the expected range. The 2015 figure was 1.6%.

(Source: CQC Insight - National Vascular Registry)
**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.6%. This placed the trust within the top 25% of all trusts for this measure. The 2015 figure was 4.5%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9% which was similar to the national aggregate. The 2015 figure was 41.6%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: CQC Insight - National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), the Royal Oldham Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 103 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 62 cases.

The hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 67 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 48 cases.

The risk-adjusted 30-day mortality for The Royal Oldham Hospital was within the expected range based on 217 cases.

(Source: CQC Insight - National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
Between April 2016 and March 2017 performance on groin hernias, hip replacements and knee replacements was about the same as the England average.

For varicose veins, performance was about the same as the England average, aside from the Aberdeen Varicose Vein Questionnaire where performance was worse than the England average. *(Source: NHS Digital)*

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Patients who attended for colorectal or general surgery and General Surgery had a lower than expected risk of readmission for elective admissions when compared to the England average. The hospital performed well in the 2016 National Emergency Laparotomy Audit (NELA).

From the 2016 hip fracture audit, the number of patients having surgery on the day of or day after admission was worse than the national standard. The perioperative medical assessment failed to meet the national standard. This was highlighted in the last report as not meeting British Orthopaedic Association Standards (BOAST). An action plan was in place with some areas completed with recommendations and others on-going or progressing.

### Competent staff

#### Appraisal rates

Between June 2016 and May 2017, 79% of staff working within the Surgery & Anaesthesia division at the trust had received an appraisal compared to a trust target of 90%.

The 79% appraisal rate applies to nursing and midwifery registered, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

- At Royal Oldham Hospital 80% had received an appraisal.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service; however the rate was 80% which was lower than the trust target of 90%.

We were told that newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
The trust had introduced a nurse assessment and accreditation scheme (NAAS) to support nurses’ practice. The NAAS was developed at a neighbouring trust to address inconsistencies and gaps in assurance and quality of nursing care. It advocated best practice, good leadership and public engagement to provide safe care. The NAAS focused on standards of care, such as pain management, nutrition and hydration, end of life care, person centred care and Infection control.

The wards were assessed in their NAAS performance and rated. All wards had been rated once over the year and three wards had been rated a second time. Ward T7 was assessed as red in March 2017, however, this had greatly improved to green in September 2017. Ward T5 was assessed as amber in December 2016; however, this had declined to red in May 2017. Ward T3 was assessed as amber in December 2016 (due for reassessment) and ward T6 was amber in September 2017. Ward T4 was assessed as red in May 2017.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

There was effective internal multidisciplinary team (MDT) working that included physiotherapists, occupational therapists, dieticians and pharmacists as well as doctors and nurses.

A mental health liaison team of professionals from the rapid assessment and interface discharge (RAID) team, who were employed by a neighbouring trust, were available and responded in a timely manner when requested.

We reviewed 16 patient records. These indicated that a range of professionals and family members/carers were consulted as part of discharge planning processes. There was good external MDT working, which included GPs and neighbouring trusts.

Patient records showed that there was regular and routine input and reviews from allied health professionals, such as physiotherapists, as well as nursing and medical staff.

Seven-day services

Acute and emergency surgical services were available seven days a week. Medical and anaesthetist cover was provided outside of normal working hours and nursing staff told us they felt well supported during these periods.

There was also a designated emergency surgical triage unit available to assess patients who may require emergency surgery. The unit was open 24 hours a day, seven days a week.

Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards during out of hours periods. There was also on-call cover provided by consultant surgeons, who were not resident but could be contacted by telephone.

Microbiology, imaging (for example x-rays and scans), physiotherapy and pharmacy support was available on call outside of normal working hours.

Access to information

Staff told us that electronic systems were not always reliable, which meant delays in accessing results from diagnostic tests could delay patient treatment.

Staff told us that information about patients they cared for was easily accessible. Staff could access information, such as policies and procedures, from the trust’s intranet.

Discharge letters were forwarded electronically to GPs and patients were provided with a copy.

Information about quality and performance were displayed both for patients and for staff.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Written consent prior to surgery was generally obtained on the day of surgery, rather than at preoperative clinic.

Royal College of Surgeons guidance recommends that written consent be obtained during the preoperative period and be re-confirmed on the day of operation. This means that patients can consider their decision during that period.

Patient records showed verbal or written consent had been obtained from patients before planned care was delivered.

Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards (DoLS). If patients’ lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved the patient’s representatives and other healthcare professionals appropriately.

Capacity, consent and DoLS were considered and adjustments, such as access to specialist support, flexible visiting, carer support and environmental considerations were applied for patients living with a cognitive impairment, such as dementia, or for those patients living with a learning disability.

Mental capacity (MCA) training was included as part of safeguarding training, which was mandatory. The trust target for safeguarding training was 90%. From data provided by the trust, 91.6% of medical staff had received training for adult safeguarding level two and 93.7% of nursing staff for the planned care division.

We reviewed 13 care records that included that capacity assessments had been completed appropriately. However, during the inspection we noted that for one patient for whom a Deprivation of Liberty (DoL’s) application had been submitted, there was no evidence that a capacity assessment had been completed. There was only a written record in the patient’s medical notes that the patient was assessed to lack capacity.

An interpreter service assisted with consent for patients whose first language was not English.

Is the service caring?

Compassionate care

Friends and Family test performance

Between August 2016 and July 2017 the Friends and Family Test response rate for Surgery at The Pennine Acute Hospitals NHS Trust was 26% which was slightly worse than the England average of 29%

A breakdown of response rate by site can be viewed below.
A breakdown of percentage recommended by site and ward is shown below:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Respondents</th>
<th>% Recommended Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fairfield General Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daycare</td>
<td>10210</td>
<td>94%</td>
</tr>
<tr>
<td>FO9</td>
<td>410</td>
<td>100%</td>
</tr>
<tr>
<td>FO14</td>
<td>270</td>
<td>100%</td>
</tr>
<tr>
<td>Ward W1</td>
<td>372</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Rochdale Infirmary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daycare</td>
<td>4322</td>
<td>90%</td>
</tr>
<tr>
<td>NC3</td>
<td>429</td>
<td>92%</td>
</tr>
<tr>
<td>NC4</td>
<td>262</td>
<td>98%</td>
</tr>
<tr>
<td>ND5</td>
<td>388</td>
<td>82%</td>
</tr>
<tr>
<td>ND10</td>
<td>183</td>
<td>54%</td>
</tr>
<tr>
<td><strong>North Manchester General Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NF3</td>
<td>201</td>
<td>51%</td>
</tr>
<tr>
<td>NF4</td>
<td>307</td>
<td>100%</td>
</tr>
<tr>
<td>NF5</td>
<td>104</td>
<td>100%</td>
</tr>
<tr>
<td>NF6</td>
<td>154</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Royal Oldham Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Ward</td>
<td>101</td>
<td>100%</td>
</tr>
<tr>
<td>Daycases</td>
<td>10078</td>
<td>94%</td>
</tr>
<tr>
<td>Endoscopy Unit</td>
<td>416</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Royal Oldham Hospital</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients described excellent care from all staff. This included nurses, doctors, allied health professionals and administrative staff.

All staff introduced themselves and communicated well to ensure patients fully understood.

Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.

Patient feedback results in the NHS Friends and Family Test (FFT) showed that between 80% and 100% of patients would recommend the service to friends and family, with a response rate of 22%.

Staff involved patients and those close to them in decisions about their care and treatment.
Patients also told us that staff of different grades, roles and responsibilities provided superb care. Patients and families were encouraged to provide feedback, about the clinic. Boxes were available on all wards.

We observed staff interacting positively with patients and those close throughout the wards. Staff spoke to patients sensitively and appropriately dependent on individual need.

There were patient information boards that were not consistent across the wards. Some had privacy blinds that covered patient details; however, these were not always in place. The boards were positioned in public areas of the ward.

Detailed patient handovers and safety briefings took place in private offices; however, there were also bedside handovers for staff allocated to those patients. We were told that these bedside handovers were to introduce staff and check documentation, however, information about care was shared that could be overheard by other patients in the bays. This was discussed with the ward manager to address with ward staff.

Understanding and involvement of patients and those close to them

We observed staff interacting positively with patients and those close to them across surgical services. Staff spoke to families sensitively and appropriately, dependent on individual need.

Staff respected patients’ choices and delivered their care with an individualised person-centred approach. Patients care records were individualised to take into account personal wishes.

Patients and those close to them told us they received information about care and treatment in a manner they understood.

There was a selection of leaflets and patient information available to support families if required.

Family members were encouraged to attend with patients.

Emotional support

We observed staff providing reassurance and comfort to patients.

Staff provided emotional support to patients to minimise their distress. We observed staff responding calmly and professionally with a number of vulnerable patients on different wards.

Patients told us they were supported with their emotional needs.

A mental health liaison team of professionals were available and responded in a timely manner when requested.

There were specialist staff available, such as palliative care team nurses, colorectal specialist nurses, and critical care outreach nurses, to provide support to patients in times of need.

Patients were asked about what support they had at home.
Is the service responsive?

Service planning and delivery to meet the needs of local people

The trust planned and provided services in a way that did not always meet the needs of local people, as certain specialities were not available at all locations, for example vascular services were only available at Oldham.

Patients were referred to the hospital for non-elective surgery via accident and emergency or GPs. There was a critical care unit for patients who deteriorated.

A variety of services were available as part of the trust at other locations.

All non-elective trauma and orthopaedics was based at Oldham. Patients identified as MRSA positive would be nursed in Oldham for elective orthopaedic surgery.

Patients who were booked for planned surgery attended health checks prior to the operation to assess their fitness for surgery.

Average length of stay

Trust level: Elective Average Length of Stay

Between June 2016 and May 2017:

- The average length of stay for all elective patients at the trust was 2.6 days, which is lower than the England average of 3.2 days.
- Average length of stay for Trauma & Orthopaedics, Urology and General Surgery elective patients at the trust is lower than the England average.

Trust Level: Non-Elective Average Length of Stay

Between June 2016 and May 2017:

- The average length of stay for all non-elective patients at the trust was 5.1 days, which is the same as the England average.
- Average length of stay for General Surgery non-elective patients at the trust was 4.0 days, which is the same as the England average.
- Average length of stay for Trauma & Orthopaedics and Urology non-elective patients was similar to the England average.
Royal Oldham Hospital: Elective Average Length of Stay

Between June 2016 and May 2017;
- The average length of stay for all elective patients at Royal Oldham Hospital was 3.1 days, which is similar to the England average of 3.2 days.
- Average length of stay for vascular surgery, Trauma & Orthopaedics and General surgery elective patients is lower than the England average.

Royal Oldham Hospital: Non-Elective Average Length of Stay

Between June 2016 and May 2017;
- The average length of stay for all non-elective patients at Royal Oldham Hospital was 5.5 days, which is similar to the England average of 5.1 days.
- The average length of stay for General Surgery non-elective patients 4.0 days, which is the same as the England average.
- Average length of stay for Trauma & Orthopaedics and Vascular surgery non-elective patients is lower than the England averages.

(Source: Hospital Episode Statistics)

The average length of stay for patients was generally similar to the England average for both elective and non-elective surgery.

Waiting times from treatment were and arrangements to admit treat and discharge patients were in line with good practice.

The average length of stay for all elective patients was similar or lower than the England average as above.

Meeting people’s individual needs

There were good systems in place to meet the needs of patients whose circumstances made
them vulnerable.

Patients living with a cognitive impairment, such as dementia, were assessed within the general multi-disciplinary team, nursing and medical processes. Staff used a ‘this is me’ document for patients admitted to the hospital with dementia.

The hospital had implemented the ‘forget-me-not’ sticker scheme. This was a discreet symbol used as visual reminder to staff that patients were living with dementia or were confused. They also supported ‘John’s Campaign’ for dementia patients. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.

For patients identified with a learning disability, a passport was completed that included key information, such as the patient’s likes and dislikes. This could be completed during the pre-operative stage of a patient’s care to ensure any reasonable adjustments which were needed were put in place.

On ward T7 there was a wide range of materials to support dementia patients, such as games and items made of different materials and textures. There were display memory boards; one included historical photos of the local area and another had classic movie stars.

The wards were painted with coloured borders around bays to identify them individually. Bathrooms including coloured toilet seats and hand rails to contrast the white walls and they were therefore easier to see.

There were packs available to help care for patients requiring specialist palliative care for different faiths and cultures with the swan end of life emblem. In addition, spiritual support was available and patient property bags were discreet cloth bags.

The trusts interpreter and translation Service provided face to face and telephone interpreting, British Sign Language interpreting and translation services to all the trust. Translation was provided by a contracted agency that could provide braille and alternative formats.

In addition, patient information leaflets available on wards were written in English, although there were instructions on how to request leaflets in a variety of formats, including languages other than English.

Ward T7 had produced printed cards with ward contact details, to give to patients or those close to them.

Bariatric equipment was available if needed. We were told that the preoperative clinic was planning to convert a consulting room to allow larger wheelchair access.

There were a range of specialist staff available to support ward staff, such as end of life nurses, dieticians, physiotherapists, occupational therapists and a colorectal nurse specialist.

Wards promoted ‘themes of the month’, such as focusing on falls, pressure ulcers and diabetes. The trust had also implemented their end ‘PJ paralysis’, which is an initiative to promote mobilisation and independence.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

20171019 900885 Post-inspection Evidence appendix template v2.0 Page 265
Between August 2016 and July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for Surgery has been consistently better than the England average.

As of July 2017 73% of patients were treated within 18 weeks compared to the England average of 70%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, three of the specialties were above the England average and three of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>96.1%</td>
<td>74.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>85.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>81.9%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>74.8%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.9%</td>
<td>77.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>65.2%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>62.4%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Between Q2 and Q4 15/16, the trust slightly improved performance so that no patients had to wait longer than 28 days for treatment after their operation was cancelled. This was despite the number of cancelled operations rising during the period from 191 to 308.

However in Q1 16/17 performance declined so that although the number of cancelled operations had reduced to 215, 8% of those patients were not treated within 28 days of their cancellation.

The declining trend has continued until Q1 17/18 and 8% of the 326 patients whose operation was cancelled, did not receive treatment within 28 days.
Over the two years, the percentage of cancelled operations at the trust showed an overall trend of decline. Q1 and Q2 16/17 saw some improvements, although has been deteriorating since. Throughout the period the percentage of cancelled operations was generally higher than the England average.

Cancelled operations as a percentage of elective admissions includes only short notice cancellations.

Cancelled Operations as a percentage of elective admissions - The Pennine Acute Hospitals NHS Trust

(Source: NHS England)

People could generally access the service when they needed it. The service took account of patients’ individual needs.

Patients admitted via accident and emergency were reviewed in the emergency surgical triage unit. Elective patients were reviewed by the surgeon and anaesthetist on the day of surgery to ensure medically fit for the procedure.

Between June 2016 and May 2017, 46% of patients did not have a bed move. There were 31% of patients that moved once, 16% moved twice, 5% moved three times and 2% moved at least four times. Of these 1, 575 patients were moved at night.

Information received from the service showed that between April 2016 and June 2017, the theatre utilisation was between 74% and 82%, which was consistently below the target of 85%.

Between April 2016 and June 2017, there were 13 patients that had been cancelled and re-booked within 28 days of the cancellation, although there was an average of 22 operations cancelled monthly for non-clinical reasons.

Between August 2017 and October 2017, there were 707 patients identified as medical outliers in the surgical wards. During the inspection we were told that these patients had been reviewed appropriately; the only reports of a delay was during an emergency situation in another department.

Between May 2017 and October 2017, information from the trust showed that 28 patients needed to be stabilised in the recovery area of theatre prior to transfer to another care area. Of these,
nine were after 9pm at night due to a lack of high dependency (level 2) beds in the hospital.

On the trust’s common scorecard October 2017, it was stated that in August 2017 the referral to treatment (RTT) performance was 87% and in September it was 88%. The standard of 92% had not been achieved. (Includes Rochdale as reported in the care organisation).

Between August 2017 and October 2017, a total of 143 operations were cancelled on the day, with the list overrunning as the most common reason for cancelling.

### Learning from complaints and concerns

#### Summary of complaints

Between June 2016 and May 2017 there were 257 complaints about Surgery (31.6% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 65 complaints still open and yet to be completed.

There were 109 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 42%.

Royal Oldham Hospital: There were 101 complaints (39.3%)  
(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

The service did not investigate complaints in a timely manner, as above, as per their policy.

Information about complaints procedures were available in all wards we visited. There were details on cards and leaflets about the patient advice and liaison service (PALS).

Complaints were recorded on the trust-wide system. Local ward managers were responsible for investigating complaints in their areas.

Information from the trust showed that between July 2017 and October 2017, a total of 38 complaints had been received, however; this information did not include any details about individual complaints

Lessons learnt from complaints were shared at safety huddles and ward meetings. It was not clear if lessons were shared across the trust.

### Is the service well-led?

#### Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There were clearly defined and visible leadership roles across the surgical division. The senior management team included a divisional managing director, a divisional clinical director and a divisional director of nursing.

The leads were supported by a team of matrons and ward and theatre managers. The length of service of the leads varied and it was not clear how embedded the service was with the changes in leads.

Matrons were visible in all areas on a daily basis. Matrons attended ‘bed meetings’ daily to discuss nurse staffing, to ensure safe numbers of staff for the acuity of patients.

Medical and nursing staff understood management reporting structures and told us they were
well supported by their managers. Senior managers told us that they had attended away days to discuss and share best practice.

**Vision and Strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The surgical service group mission statement was: “Saving Lives, Improving Lives” by delivering highly reliable services at scale, which are trusted, connected and pioneering.

The surgical division had an operational plan that included strategic themes and a plan of priorities in implementing the strategies.

The values of the organisation were displayed in areas throughout the service for staff and patients to see.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The culture of the surgical division was aligned with the trust values. There was an open and transparent culture that encouraged the reporting of incidents in order to learn from them and improve quality for people in the local population, although there was recognition from senior managers that this could be improved.

There was a positive attitude and culture within the Surgical Division where staff valued each other. Staff from all specialities reported good team working and a sense of pride in serving the local community.

The length of service of staff at the trust we spoke with varied, but all staff demonstrated strong commitment to the hospital.

**Governance**

A clinical governance system was in place within the surgical division that allowed risks to be escalated to divisional and trust board level through various committees and steering groups.

Clinical governance / audit meetings took place bi-monthly; regular agenda items included review of NICE guidelines, local / national audits and mortality reviews.

Clinical effectiveness meetings took place. From these, the WHO Checklist was relaunched in August 2017.

There were weekly meetings held to discuss serious incidents, including the application of duty of candour.

The service collected data to monitor and improve performance. Theatre dashboards captured compliance with five steps to safer surgery in real time. Audits were carried out twice yearly, although this captured both adults and paediatrics trustwide.

The service had recruited a surgical surveillance nurse to monitor surgical site infections for orthopaedics and vascular going forward.

Performance meetings were held across the service in order to share best practice.

**Management of risk, issues and performance**
The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a surgical risk register that identified risk across departments and risks identified had control measures with assurances included.

Staffing both medical and nursing were included in risk registers. Managers told us that ‘one stop’ recruitment events had taken place and there were plans for further events.

Senior managers were clear about their roles and there was evidence that quality and risk were managed appropriately.

Waiting times initiatives were arranged to monitor performance appropriately for patients.

**Information Management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Paper patient records were securely stored in locked trolleys, whilst other records were recorded and stored electronically.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were ‘Glimpse of Brilliance’ notice boards on some wards that recognised staff contribution and efforts.

Staff told us that they attended monthly ward meetings. Staff information was displayed in office areas and information was disseminated at daily safety huddles.

Staff received information in a weekly bulletin that was issued trustwide to update staff. Senior managers told us that there were walkarounds in theatres and on the wards.

The surgical division participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed in ward areas.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.

There were no enhanced recovery programmes at the location.
Critical care

Facts and data about this service

For management and governance purposes, the critical care unit at The Royal Oldham Hospital are located in the Division of Surgery. The Division of Surgery is further divided into The Gastroenterology Directorate; Orthopaedic Trauma and Vascular Directorate; General and Colorectal Surgery Directorate and the Clinical Support Services Directorate, which is where the critical care unit is located. The Division of Surgery is led by a Divisional Clinical Director, Managing Director and Director of Nursing, who are supported by a Directorate Manager, Clinical Director, Assistant Director of Nursing and Directorate Manager for critical care units.

There are a total of 34 critical care beds across three of the trust sites.

North Manchester General Hospital has a 12 bedded critical care unit, comprising of six level 3 beds and six level 2 beds, with flexibility to increase the number of level 3 beds if necessary. The unit operates a consultant-led service.

Fairfield General Hospital has a six bedded critical care unit - this is a closed unit flexing between Level 3 ICU beds and Level 2 HDU beds as required. This is a consultant led service.

The Royal Oldham Hospital has a 16 bedded critical care unit with eight level 3 intensive critical care beds and eight level 2 HDU beds.

(Source: Trust Provider Information Request – Context Acute)

A breakdown of these beds by type is below.


<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 24.4%</td>
<td>Neonatal, 24.0%</td>
</tr>
<tr>
<td>Adult, 75.6%</td>
<td>Adult, 68.2%</td>
</tr>
<tr>
<td>Paediatric, 7.7%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

The Intensive Therapy and High Dependency Units, that form the Critical Care Unit, are located on the second floor of the main building at The Royal Oldham Hospital. The two units are separated by a corridor. Both units had side rooms, so that patients could be isolated if they presented an increased infection control risk, or if privacy for the patient was required.

Intensive Care National Audit and Research Centre (ICNARC) data for April 2016 to December 2016 shows that there were 260 admissions to the Intensive Therapy Unit (ITU) at The Royal Oldham Hospital and 542 admissions to the High Dependency Unit (HDU). Both HDU and ITU have 2920 available critical care bed days per year.

Of the 260 admissions to ITU, 44 of the patients died on the unit and a further 18 patients died
before being discharged from hospital. Of the 542 admissions to HDU, 35 of the patients died on the unit and a further 55 patients died before being discharged from hospital.

The ITU has medical leadership from intensivists/anaesthetists 24 hours a day, seven days a week. The HDU has medical leadership from 8am to 6pm each day. When we carried out our last inspection, there was no medical leadership cover for the HDU. There is joint nursing leadership across the two units.

The service is a member of the Greater Manchester Critical care Network (GMCCN) that engages with clinicians, commissioners and managers to contribute to the effective development of critical care services within the region for the benefit of all critically ill patients.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff.

**Mandatory training completion rates**

The trust set a target of 90% completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in Critical Care are shown below:

![Mandatory Training Completion (Medical & Dental)](image)

Medical and dental staff working in Critical Care failed to meet the 90% target for mandatory training completion for 10 of the 16 modules.

Staff did achieve or exceed the target for the remaining six modules with 100% of eligible staff completing the advanced paediatric life support training.

Basic life support and paediatric basic life support had the lowest compliance levels with only 71% and 50% of eligible staff having been trained.
Nursing and midwifery staff working in Critical Care achieved or exceeded the 90% target for 11 of the 15 modules, with 100% of eligible staff completing paediatric basic life support and advanced life support training.

PREVENT training had the lowest compliance levels with 83% of eligible staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in Critical Care is shown below:
Medical and dental staff working in Critical Care at the trust met the 90% target for both safeguarding adults level 2 and safeguarding children level 2, but only achieved 76% compliance for level 3 children’s which equated to 10 of the 13 eligible staff completing the training.

Nursing and midwifery staff working in Critical Care at the trust exceeded the 90% completion target for both level 2 adults and level 2 children’s safeguarding. 84% of nursing and midwifery staff had completed level 3 adults safeguarding, which equated to 47 of the 56 eligible staff completing the training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were aware of how to complete an online safeguarding referral. Any potential safeguarding issues were identified in the nursing handover and discussed in daily safety huddles.

Cleanliness, infection control and hygiene

The service controlled infection risk, though we did observe some lapses in controls on the units. Clinical areas, offices, corridors and store rooms were visibly clean. Floors were covered in a wipeable material, as were chairs and couches.

The trust had infection prevention and control policies in place and these were accessible to staff.

Staff on the unit were ‘arms bare below the elbows’ in clinical areas and washed their hands after touching patients. Staff were using personal protective equipment (PPE), such as gloves and aprons and changed this equipment between patient contacts, in line with trust policy.

There was adequate access to hand washing sinks and hand gels. Hand gels were available outside the doors to both ITU and HDU and staff and visitors were reminded to use them before entering.

Both ITU and HDU had siderooms, so that patients with a suspected infection could be isolated.

Curtains were disposable and clean, there were foot operated waste bins in use and clinical waste was stored securely.

Cleaning was carried out twice a day on the unit by a contracted cleaning company.

Staff were aware of the recommended cleaning products for hubs and ports of indwelling devices and how specimens should be stored and transported to pathology laboratories.

A relative told us that the high dependency unit felt safe and was very clean. There was an
infection prevention factsheet for patients and visitors.

The most recently supplied Intensive Care National Audit and Research Centre (ICNARC) data for the period April to December 2016 showed that there had been no unit acquired blood infections in either ITU or HDU in that period.

At the time of our inspection, the critical care units reported that they had no cases of methicillin resistant staphylococcus aureus (MRSA) for 263 days and no cases of Clostridium difficile (C difficile) for 102 days. However, there was at least one patient in ITU who had reported C difficile at the time of our inspection, so we were not assured as to how accurate these figures were.

We noted that “I am clean” stickers, to show when equipment had been cleaned, were available, but rarely used in ITU. A mop and bucket symbol, on which to write the date of the last deep clean, was available on the wipe-able boards behind the beds. However, we spoke to a cleaner who told us that they were not used.

We saw that some curtains around bed areas did not have a date on them as to when they had last been changed although they were disposable and did appear clean.

We saw that sharps bins were routinely left open throughout the units and one bin was overly full because a syringe was seen to be sticking out of the top. One of the sharps bins in ITU had blood splatters on it. This was next to a blood gas machine that was observed to have blood drops on the machine draw. There was a notice by the machine advising that it must be cleaned after every use, but we observed that the blood was still on the machine the following day. The machine was cleaned when it was raised with a member of staff.

Environment and equipment

The service did not have suitable premises in terms of available space but equipment was looked after well.

In terms of the environment, the critical care units were not compliant with the Department of Health published “Health Building Note 04-02” (HBN 04-02) for critical care units. This guidance determines the equipment that needs to be located in a critical care unit and the minimum amount of space required per bed to safely locate and utilise that equipment. The guidance states that each bed space should be a minimum of 25.5m². The unit manager told us that none of the bed spaces in HDU or ITU met this standard. The issue was on the risk register.

The long-term solution to address the issue was to build a brand new, integrated Critical Care Unit in a planned extension to the main hospital building. The timescale for this was two years. In the short-term, risks to patients were minimised by keeping the floor space around the bed as clear as possible, infection control monitoring and use of aseptic non-touch technique. The issue with bed spaces and proposed solutions was on the risk register.

The service kept an inventory of all equipment. There was an electro bio-medical engineering department (EBME) on site, who were responsible for servicing and maintaining bio-medical equipment in the Critical Care Unit. They kept a pre-planned maintenance schedule and ensured that 90% of equipment was serviced within three months of the due date and 95% of equipment was serviced within six months of the due date. We examined two Sonosite ultrasound machines that were in an equipment store and saw that one was due for servicing in October 2017 and the other was due for servicing in June 2018. We were told that the EBME team would deal with any equipment malfunctions in a timely manner.

The Critical Care Unit directorate manager was responsible for the replacement of equipment that was specific to critical care and there was a capital replacement program in place.

There was a large area next to the existing HDU that was used as a joint equipment store for ITU and HDU. Numerous pieces of equipment were stored and charged in there.

Training records and interviews with managers and the practice-based educator, confirmed that staff received training on new equipment and periodically self-verified their competencies on
equipment that they used regularly.

We saw that resuscitation equipment, including defibrillators and difficult airways management trolleys, were available on the units. There was a pictorial record of how the resus trolley should be stocked. Records showed that the top shelf of the trolley was checked daily. All resuscitation equipment was checked weekly and there was a three-monthly check of the equipment by the matron.

Clinical stores were neat and labelled and stores were found to be in date. However, there were some boxes of medical supplies stored on the floor in the storeroom behind the nurses’ station in ITU.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen.

There was a fortnightly mortality and morbidity multidisciplinary team meeting, at which each patient’s case was discussed with a view to escalating care and treatment where required or moving the patient closer to a discharge date where there was evidence that the risk of the patient deteriorating was reducing. The meeting was attended by consultants, junior doctors, the assistant director of nursing, the ICNARC clerks and a microbiologist. We observed the meeting during our inspection.

The unit had a plan in place in the event of a flu epidemic over the winter period. The plans involved the capability to increase the number of level 3 patients by 100%, by using the existing HDU. Level 2 patients would be moved to theatre recovery. However, there were only two spare ventilators and a business case had been made to obtain another three. There were also longer term plans to commission the old HDU (currently used as an equipment store) to provide another four ITU beds in there if necessary.

Staff carried out “Safety Huddle” meetings once a day where specific patient needs were discussed.

Patient records showed that staff carried out risk assessments on admission and on an ongoing basis to identify patients at risk of specific harm, such as pressure ulcers, risk of falls or nutritional risks. If staff identified patients susceptible to these risks, patients were placed on a relevant care pathway to reduce the risks, such as pressure care using suitable equipment.

The hospital used a national early warning scores (NEWS) system. This was a scoring system with the aim of identifying deteriorating patients early and quickly. The early warning scores used an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation. We saw evidence of the use of national early warning scores in the Critical care Unit in patient records.

The critical care outreach team provided monitoring and support for patients discharged from the Critical Care Unit to prevent readmissions. They also provided support and teaching to ward staff, to ensure that patients at risk of deterioration and who may require admission to the Critical Care Unit were identified in a timely way.

However, the outreach team did not cover all ward areas and did not provide cover at night. Their work was covered at night by the night nurse practitioner team. There was a proposal in place to increase the size of the team to cover nights and more ward areas.

Nurse staffing

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in Critical Care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
</table>

20171019 900885 Post-inspection Evidence appendix template v2.0
December 16 | 161.87 | 164.19  
January 17 | 164.48 | 164.19  
February 17 | 164.43 | 164.19  
March 17 | 166.43 | 163.19  
April 17 | 165.26 | 163.99  
May 17 | 163.89 | 175.17  

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

At the time of our inspection, a business case identified where nursing staffing could be increased to ensure that the service complied with Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards.

At our last inspection the clinical care outreach team only covered half of the wards in the hospital and this remained the case during our latest inspection.

The critical care outreach team delivered key aspects of the trust’s patient safety agenda by supporting clinical teams on the general wards. This included early identification of patient deterioration, timely admission to a critical care bed when required and delivery of effective follow-up for patients post-discharge. They were also responsible for providing educational support and enhancing skills and knowledge of the ward teams when caring for the at-risk and deteriorating patient.

Where escalation of care was required this was facilitated by the team in a timely manner. The current outreach team reviewed all unplanned admissions or readmissions to the Critical Care Unit, identifying if there had been a failure to escalate treatment.

In addition to the unplanned admission work, the outreach team, alongside the resuscitation teams, reviewed the cardiac arrest data and metrics data to identify ‘hotspots’ within the trust, identify the areas in trust where extra support may have been required.

The critical care outreach team linked with the out of hours practitioner teams (Night Nurse Practitioners (NNP)) with the aim to provide continuity of care over the twenty four hour time frame. The proposal was to bring the critical care outreach team cover in line with critical care Guidelines for the Provision of Intensive Care Services (GPICS), so cover was provided 24 hours a day, seven days a week. The lack of full cover provided by a critical care outreach team for 24 hours a day, seven days a week was not on the departmental risk register.

Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that there must be a supernumerary clinical co-ordinator (sister or charge nurse, band 6 or 7) on duty 24 hours a day, seven days a week on critical care units.

The responsibility of the clinical coordinator was to provide nursing leadership and support to optimise safe standards of patient care on each shift; coordinate and supervise nurse staffing; facilitate admissions and discharges to ensure effective patient flow; liaison with the multidisciplinary team and other departments to ensure efficient, effective and safe care is delivered in a timely manner.

At the last CQC inspection, there was no clinical co-ordinator on either HDU or ITU at The Royal Oldham Hospital. At our latest inspection there were supernumerary clinical co-coordinators on ITU from 07:30 to 20:30, but there were no supernumerary clinical co-coordinators on HDU. This meant that, when there was no supernumerary clinical coordinator a lead nurse, who was not supernumerary, had to take on the responsibilities of the clinical coordinator and this had the potential to impact on safe patient care.

There was a business case in place to increase the band 5 nurse establishment on the late and
night shift to release the band 6 or 7 nurse on duty into the supernumerary clinical co-ordinator role, so there was a clinical co-ordinator on duty 24 hours a day, seven days a week. The business case also allowed for the appointment of a Matron (who was in post at time of the inspection); increase of the critical care outreach team to cover all wards in the hospital and to allow cover for 24 hours a day, seven days a week. Finally, the business case that was the preferred option allowed provision of a follow-up clinic for all patients discharged that had been ventilated for longer than four days. If all these changes are put in place, several standards from the critical care Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards would be met that were not being met at the time of our inspection. The timescale for implementing all the changes was not clear.

Since our last inspection a matron had been recruited to the unit as identified.

We examined the nursing rotas for the units on our inspection for several weeks around the time of the inspection and found that they were fairly consistent. There were sufficient staff to cover the units at one nurse per level 3 bed and one nurse per every two level 2 beds. However, we were told that, when staffing levels were achieved, excess nursing staff would be moved on a daily basis, to other wards or Fairfield General Hospital. This was not reflected in the nursing rotas on the critical care unit so we could not be assured that the nursing staff levels recorded were actually the number on duty on the unit. Numbers of staff moved to other units or wards were not recorded in the records. For example, we were told that, on the first day of our inspection, there were eight registered nurses displayed on the rota as working in ITU, but two nurses had been sent to work elsewhere. An additional three nurses working in a supernumerary capacity meant that safe staffing levels were maintained on the unit but the rota did not reflect the actual number of staff working as the figures had not been amended to reflect the staff who had been moved elsewhere.

Trust records showed that the average shift fill rate during the day was 87.47% for nursing staff and 73.17% for care staff and at night was 94.89% for nursing staff and 93.55% for care staff. These figures were all below the trust target of 95%.

Recruitment and retention of nursing staff was under review as managers were aware that most of the band 7 nurses would be eligible for retirement within the next 12 months.

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 1.2% for nursing and midwifery staff in Critical Care;

- Royal Oldham Hospital: 1.2%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 7.8% for nursing and midwifery staff in Critical Care;

- Royal Oldham Hospital: 11.5%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.7% for nursing and midwifery staff in Critical Care, which is higher than the trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 5.7%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Managers and the practice-based educator told us that all agency staff used on the unit were from NHS Professionals and received a local induction. Most worked on the unit on a regular basis so there was a familiarity with other staff and working procedures. There had been an increased use of agency staff over the last year because there were seven nurses on maternity leave at the time of our inspection.

**Medical staffing**

The trust has reported the following planned and actual staffing figures for medical and dental staff working in Critical Care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>23.00</td>
<td>24.79</td>
</tr>
<tr>
<td>January 17</td>
<td>23.00</td>
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<tr>
<td>March 17</td>
<td>23.00</td>
<td>25.54</td>
</tr>
<tr>
<td>April 17</td>
<td>23.00</td>
<td>26.54</td>
</tr>
<tr>
<td>May 17</td>
<td>22.00</td>
<td>26.85</td>
</tr>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

At the time of our last inspection, in February 2016, there was no consultant cover at all on the high dependency unit of Royal Oldham Hospital. At this inspection there was now consultant cover from 8am to 6pm every day. This was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards for critical care units that states that care must be led by an intensivist in intensive care medicine and that a consultant must be available 24 hours a day seven days a week and lead twice daily ward rounds. The existing consultant cover during the day was seen as an interim measure. Royal Oldham Hospital is the only hospital in Greater Manchester that has an “open” high dependency unit and this has been flagged as a serious concern by the Greater Manchester Critical Care Network.

At the time of our inspection, care on the high dependency unit was led by the “parent teams” from 6PM to 8AM. The parent teams were the medical teams throughout the hospital, led by a consultant who was responsible for the patient with regards to their underlying condition, for example a specialist renal consultant. Care was often provided by junior doctors who had no critical care experience and were tasked with making the decision to admit a patient to critical care. This led to inappropriate admissions to the unit, for example, patients who were not expected to survive and for whom there would be no benefit in transferring to a high dependency unit. Often these patients would not be assessed by a critical care consultant intensivist within the required 12 hour timescale.

In order to try to reduce the number of inappropriate admissions to the unit registrars who were considering an admission overnight were required to discuss the case with the specialist consultant for the parent team (who may be on-call) and they needed to support the decision to admit the patient to HDU. This had been in place for around three months and the lead consultant in critical care believed that this was beginning to have an impact on the numbers of inappropriate admissions to the unit though a further audit to assess the impact had not yet taken place. There had been three deaths on the unit within the last three months where the patient
had been admitted out of hours by the “parent team” and had died within 24 hours of admission. There was a business case in place to ensure that the HDU at The Royal Oldham Hospital could be staffed by consultants and speciality doctors for 24 hours a day, seven days a week. This involved the recruitment of a further four consultants and seven speciality doctors. This would bring the number of consultants covering HDU and ITU to 12. Since the last CQC inspection, one consultant had been recruited but two had retired and one had gone to work elsewhere within the hospital, so the staffing levels had not improved and this had not allowed for complete cover on HDU to take place.

The successful recruitment of four consultants and seven middle grade doctors would allow for a team of resident intensivists providing 24 hours a day, seven days a week cover on full shift and a consultant cover on the unit for 10 hours a day Monday to Friday and six hours a day on Saturdays and Sundays, with non-resident on-call support on evening shifts and overnight. The unit would then be compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards.

We were told that currently consultants on the unit often had to cover for absences at Fairfield General Hospital.

In ITU, clinical consultant-led ward rounds took place once a day, every day of the week. Out of hours, there was always a consultant on call.

Vacancy rates
Between June 2016 and May 2017, the trust reported an average vacancy rate of 16.9% for medical and dental staff in Critical Care;

- Royal Oldham Hospital: 48.4%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
Between June 2016 and May 2017 the trust reported an average turnover rate of 36.1% for medical staff in Critical Care;

- Royal Oldham Hospital: 20.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Between June 2016 and May 2017, the trust reported an average sickness rate of 0.3% for medical staff in Critical Care which is better than the overall trust target of 4.6% for sickness rates.

- North Manchester General Hospital: 0.1%
- Fairfield General Hospital: 0.6%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Allied health professional staffing
The Critical Care Unit at The Royal Oldham Hospital was not compliant with Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards in staffing numbers for allied health professionals (AHPs) required to meet the needs of patients over seven days a week. There was a business case setting out the number of staff required to meet the Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards on staffing seven days a week. However, the timescale for implementing the changes was not clear.
Physiotherapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards dictate that there should be input from physiotherapy on the daily ward round and there must be a physiotherapist of adequate experience and seniority who can construct a suitable weaning plan for complex patients. Physiotherapy staffing must be adequate to provide the respiratory management and rehabilitation components of care. The suggested staffing levels are that there should be one physiotherapist to every four beds.

At the time of our inspection the physiotherapy establishment was 1.57 whole time equivalent (wte). The business case for an increase in allied health professional staff to comply with Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards with a seven day service, calculated that an establishment of 5.75 wte physiotherapists was required. This allowed for seven day shift patterns and annual leave etc.

The lead physiotherapist was involved in the fortnightly “grand round” multidisciplinary meeting. However, they were not involved in weaning patients from tracheostomies. This was not in line with the Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards that state “The critical care team should have a Physiotherapist of adequate experience and seniority who can help contribute/construct a suitable weaning plan for complex patients, or long stay patients, in conjunction with the wider multi-professional team.” There was no overnight on-call physiotherapist provision.

Occupational Therapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that the rehabilitation needs of patients should be assessed within 24 hours of admission into critical care and eligible patients must receive a rehabilitation prescription on discharge from critical care. Patients receiving rehabilitation should be offered a minimum of 45 minutes of each active therapy that is required for a minimum of five days a week. The suggested staffing levels are that there should be 0.22 wte occupational therapists per bed in a critical care unit.

At the time of our inspection there were no occupational therapists attached to the critical care units. The risk of patients receiving inadequate care because of this was highlighted on the risk register. At the time of our inspection, Occupational therapy was provided by the wider trust team when a referral was made to them or when an urgent need was identified. The business case for an increase in allied health professionals staffing calculated that an establishment of 6.06 wte occupational therapists was required to allow for seven day coverage on the unit.

Dietitians

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that all patients unable to take oral intake must normally have nutrition support commenced on admission. There must be a dietitian as part of the critical care multidisciplinary team and the lead dietitian will be involved in the assessment, implementation and management of appropriate nutrition support. The suggested staffing levels are that there should be 0.05-0.1 dietitians per bed in a critical care unit and that the lead dietitian should be a minimum of a band 7.

At the time of our inspection there were 0.72 dietitians (a band 7) attached to the critical care units. The business case for an increase in allied health professionals staffing calculated that an establishment of 2.2 wte dietitians were required on the units to allow for a seven day service and they would be a skill mix of band 6 and 7 staff.

Speech and Language Therapists

The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that all patients with a tracheostomy must have communication and swallowing needs assessed when
the decision to wean from the ventilator has been made and the sedation hold has started. There is no national guidance on the minimum number of speech and language therapists that should be attached to a critical care unit.

At the time of our inspection there were no speech and language therapists dedicated to the critical care unit. Current provision of speech and language therapy was provided by the wider trust speech and language therapy team. The business case for an increase in allied health professionals staffing calculated that an establishment of 2.76 wte speech and language therapists were required to allow for seven day coverage on the units. This had been calculated using the guidance for required numbers of other allied health professionals.

**Records**

Staff kept records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

We examined eight sets of patient records across ITU and HDU. The records were paper based and comprised a range of clinical records, assessments and plans.

The records on the whole showed that there was a summary of events requiring admission to critical care recorded, as well as a consultant review on admission. The records showed that there was evidence of a Venous Thromboembolism (blood clots in a vein) assessment; evidence of a daily consultant led ward round; assessment of fluid state; review of in-dwelling lines; review of sedation and antibiotics (if applicable); evidence of input from the multidisciplinary team; assessment of pressure areas and nutritional status.

However, in five out of the eight records examined, the time of the decision to admit the patient was not recorded in the records and consequently we were not able to establish whether the admission to critical care was within four hours of the decision to admit them, which was in line with expected critical care Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards.

In one instance, the decision to admit the patient had been made at 12pm, but the patient had not been admitted until 6pm, which therefore was outside the recommended timescale.

Staff told us that the IT systems were very slow and that this could impact on patient safety. We were told that staff could wait up to 30 minutes to receive required results.

**Medicines**

The service prescribed, gave, recorded and stored medicines well.

The Critical Care Unit used an electronic prescribing system, which could be accessed at the patient’s bedside.

The critical care Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that there must be a critical care pharmacist for every critical care unit. The consensus of the UK Clinical Pharmacy Association and the Royal Pharmaceutical Society is that there should be at least 0.1 wte band 8a specialist clinical pharmacists for each single level 3 bed and for every two level 2 beds. The minimum requirement does not take into account staffing for weekend service or annual leave and so on.

There were two pharmacists working in the Critical Care Unit, but they were only part time and made up one wte. The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards called for 1.2 wte pharmacy staff as a minimum. There was a business case for at least one more pharmacist to be recruited. One pharmacist worked Monday to Wednesday and the other from Wednesday to Friday. Three hours a day was spent in each unit by a pharmacist. There was no weekend cover on the units. This had the potential to impact on a timely review of patient medication during this time. There was an on-call service and a pharmacist on-site on
Saturday mornings. They did not attend the fortnightly multidisciplinary meeting, but they were available during the daily ward round if required and usually communicated any concerns to the consultant before the ward round began.

In addition there were two pharmacy technicians working alongside the pharmacist in the Critical Care Unit. However, one technician was training to work on the Critical Care Unit at the time of our inspection, as the other was going on maternity leave.

The pharmacist had access to electronic summary care records via a smart card that allowed access to medication records from GP surgeries. Patient consent was sought where possible to continue to give drugs that had been prescribed by their own GP. The prescribing process was quicker than having to wait for a GP surgery to fax through details of a patient’s usual medication.

The pharmacist reported that the hospital pathology lab system was very slow and this could affect the time that it took to prescribe the required medicines. This had the potential to impact on patient safety where drugs needed to be administered quickly, for example, in the case of an infection being diagnosed.

Patients were triaged in order of acuity for pharmacist assessment and prescribing with the most unwell patients being seen first and those who were being prepared for discharge from the unit.

Medicines on the unit were stored appropriately in locked cupboards and fridges. However, there was one fridge in ITU that was not routinely kept locked and this was in an area that was accessible to visitors. Maximum and minimum fridge temperatures were checked daily and recorded in accordance with national guidance. However, a fridge in HDU had five days missed from the daily record sheet, though there was no evidence that it had been out of range on the days before and after the missing records. Staff were aware of what to do in the event of fridge temperatures being out of range and there were appropriate arrangements in place for the destruction of unwanted and expired medicines.

Checks on controlled drugs were conducted daily by two nurses and weekly by the matron. Controlled drugs were kept in a locked room in a locked cupboard with the keys kept on the person in charge of the shift. We checked the controlled drugs book and found stocks to be recorded accurately. Patients’ personal medicines were kept separate in secure lockers in a locked room and were clearly labelled according to the bed number.

We reviewed three patient prescription charts on HDU. All were signed and dated, allergies had been documented and the administration of venous thromboembolism (VTE) prevention medication was documented. Two patients had not had antibiotics prescribed. The third patient had antibiotics prescribed, but these had not been reviewed in line with national guidance. All records were electronically produced, so there were no issues with handwriting legibility.

Incidents

The service managed patient safety incidents.

The trust had recently introduced a new electronic incident reporting system.

Some incidents that had been raised by consultants were discussed at the fortnightly mortality and morbidity MDT meeting.

Management told us that the system had made it easier for staff to report incidents and that the number of incidents reported had risen since the system was introduced. However, staff reported that they had not received training on the new system and were not reporting incidents, as they should be, although they had an understanding of what should be reported as an incident.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents classified as never events for Critical Care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in Critical Care which met the reporting criteria set by NHS England between August 2016 and July 2017.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections between August 2016/17. (Source: NHS Digital)

Safety thermometer data was displayed in the corridor of the critical care unit. The data stated that there had been no pressure ulcers for 282 days; no falls for 338 days. However, we were shown details of a pressure ulcer that had been reported as an incident in August 2017 and advised of a recent fall incident, so we could not be assured of the accuracy of these figures.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The Critical Care Units at The Royal Oldham Hospital supplied patient data throughout the year to the intensive care national audit and research centre (ICNARC). This meant that care delivered and mortality outcomes were benchmarked against similar units nationally. The critical care unit employed ICNARC clerks to maintain, collate and submit the data.

The Critical care Unit was part of the Greater Manchester Critical Care Network (GMCCN) that conducted an annual peer review of the unit. The latest report, which was published in May 2017, highlighted some areas of good practice, such as the training of two advanced critical care practitioners who are split across two sites; 100% achievement in organ donation referrals; a significant reduction in the rate of pressure ulcers on the unit and a safety checklist now included on consultant ward rounds.
However, the report also highlighted a number of concerns, some of which had been mentioned for a number of years, such as the failure to provide a follow-up clinic for patients who had been ventilated for more than four days. The report also raised concerns about overnight admissions to HDU; the physical infrastructure of the units; pharmacist cover; lack of time for the band 7 staff to complete staffing rosters; the number of nurses approaching retirement and the lack of mass casualty plans that state how they would ventilate patients in the event of an increase in level 3 patients.

There was a range of local policies and procedures and standard operating protocols in place, which referenced evidence-based guidance and these were easily available to staff on the trust intranet. There were policies in place for admission and discharge; transfer; referral to and from critical care; organ donation; life limiting treatment and withdrawal; organ donation; infection prevention and control; weaning of long-term ventilated patients and patient and carer information.

The unit undertook local audit activity, which included assessments of compliance with care bundles relating to ventilator acquired pneumonia (VAP) and skin.

The consultants had undertaken a mortality review on the high dependency unit because of worsening mortality on the unit since daytime consultant cover was introduced. The review undertook to find out the reasons for this and make recommendations to improve the situation.

Adult Respiratory Distress Syndrome protocols (ARDS) were in use on the Critical Care Units at The Royal Oldham Hospital. These helped to predict whether a patient was likely to experience respiratory distress and were calculated using bodyweight and body mass index. We saw evidence that these were in use on patient records.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration was received by patients and to prevent malnutrition.

There was a dietician on the unit and patients reported that they had been seen regularly and had their needs assessed.

Nutritional risk scores were seen to have been updated and recorded appropriately on patient notes.

There was fluid balance monitoring for patients in place, which included hourly and daily totals of input and output. We saw that they had been completed appropriately.

One relative told us that the patient was receiving adequate nutrition and hydration and a patient told us that the food was "surprisingly good".

**Pain relief**

The service had access to the Acute Pain Service in the hospital. They were available to attend the unit every day, as required.

Individual care plans included pain management assessments for all patients. This included observing the signs and symptoms of pain. Staff used a pain scoring tool.

Pain relief was routinely prescribed as part of sedation management.

Pain relief was available on request to patients who were able to ask for further pain relief.

**Patient outcomes**
The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

**ICNARC Participation**

The trust has four units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2015/16 Annual Report. More recent quarterly data may be available via the evidence grids. Any available quarterly data should be considered alongside this annual data.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Hospital mortality (all patients)**

For the intensive therapy unit at Royal Oldham Hospital, the risk adjusted hospital mortality ratio was 1.3 in 2015/16. This was worse than expected. The figure in the 2014/15 annual report was 1.2.

For the high dependency unit at Royal Oldham Hospital, the risk adjusted hospital mortality ratio was 1.4 in 2015/16. This was worse than expected and a negative outlier. The figure in the 2014/15 annual report was 1.5.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

We attended the fortnightly mortality and morbidity multidisciplinary meeting. Two patient deaths were discussed at the meeting, however, the discussion only revolved around whether meeting participants were happy with the stated cause of death. There was no discussion around assessment of care delivered, MDT working, quality of records or engagement with relatives and lessons learned from the deaths or how things could have been done better.

**Hospital mortality (for low risk patients)**

For the intensive therapy unit at Royal Oldham Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.7. This was within expected limits. The figure in the 2014/15 annual report was 1.3.

For the high dependency unit at Royal Oldham Hospital the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.5. This was within expected limits. The figure in the 2014/15 annual report was 1.9.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Patient Rehabilitation**

The Chelsea Critical Care Physical Assessment Tool (CPAX) is a tool that was developed to predict the place of discharge and rehabilitation needs of patients in critical care units. The tool scores aspects of physicality, such as respiratory function, movement, sitting, standing, balance, and grip strength and allocates score of zero to five. The overall score gives a prediction of where the patient may need to be discharged to; for example, home or a rehabilitation unit, and what their rehabilitation needs may be, for example, community support or daily nursing, required in the short or long-term.

One of the unit physiotherapists had introduced the CPAX tool and patient physicality assessments were started as soon as possible and followed through when the patients were
moved onto other hospital wards. This was in line with NICE guidelines CG83, regarding rehabilitation after critical illness in adults.

However, there was no psychologist input for patients, so patients were not formally assessed for conditions such as anxiety, depression, post-traumatic stress related symptoms and behavioural or cognitive problems. This was not in line with NICE guidelines CG83. The Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards state that patients discharged from intensive care should have access to an intensive care follow-up clinic. This is because critically ill patients have been shown to have complex physical and psychological problems that can last for a long a time. The service did not offer follow-up clinics or other post-discharge support to patients. This had been recognised in a gap analysis and was in a business case to improve the service.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and support was given to new staff.

Records showed that 78.8 wte, or 82% of nursing staff across the critical care units in The Royal Oldham Hospital, had completed the post registration award in critical care nursing. This was well above the Intensive Care Society core standard for at least 50% of staff to have completed this training, though was a reduction in the percentage of staff that had achieved the qualification at the last CQC inspection.

Records provided showed that 80% of the nursing staff had up to date training in specialised unit equipment.

New nursing staff on the unit worked eight weeks supernumerary and the service were resolved that this period would be maintained. Following the supernumerary period, nurses would commence Level 1 of the advance nurse practitioner course that they should complete within 12 months. After this, they would commence Level 2 that should be completed within 18 months and then they could apply for level 3 that led them to the critical care nursing award. This was run in conjunction with Manchester Metropolitan University.

Practice-based educators on the unit were responsible for completing the first personal development review for new staff and supported new staff through the first twelve months of their employment and completion of the step one critical care competencies. There were three practice-based educators who worked with the unit (making up two wte staff). They also carried out work with the skills institute being funded by the critical care network. The practice-based educators also arranged mandatory training courses for staff and ran acute illness management (AIM) courses on behalf of the Critical Care Skills Institute. These courses were also available to healthcare assistants.

There were a considerable number of link nurses in place who learned specialisms in clinical areas and trained other nurses in their specialisms. There were link nurses for tissue viability; point of care; end of life; diabetes; nutrition; dementia; falls; pain; basic life support; documentation; sickness monitor; stores; well-being; infection control; blood competencies; new staff induction; delirium and patient stories.

Nursing staff had to undertake an assessment package before they were judged to be competent in administering intra-venous opioids by bolus injection.

Agency and bank staff received a local departmental induction on arrival to their shifts.

Nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.

Trainee medical staff had an appraisal and revalidation process in place and opportunities to undertake training.

**Appraisal rates**
Between June 2016 and May 2017, 89% of staff working within Critical Care at the trust had received an appraisal compared to a trust target of 90%.

The 89% appraisal rate applies to nursing and midwifery registered, additional clinical services staff, allied health professionals, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Royal Oldham Hospital 84% had received an appraisal

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Up to date appraisal records showed that, at the time of our inspection appraisal rates remained similar to the above with 85% of nursing staff having received an appraisal.

Appraisals and objectives were in line with trust values and behaviours.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

There was a fortnightly multidisciplinary meeting to discuss patients on the unit and their care and treatment and also any deaths that may have occurred. We observed such a meeting that involved consultants, junior doctors, the assistant director of nursing, ICNARC clerks and a microbiologist. The pharmacist reported that they were not usually represented at this meeting.

Similarly, there was no representation from physiotherapists or dieticians and speech and language therapists. There were no dieticians or speech and language therapists who directly worked in the critical care service and formed part of the critical care multidisciplinary team.

There was a daily consultant-led ward round that took place 365 days a year. There was direct nursing input to the round. Pharmacists and physiotherapists did not usually attend the ward round directly, but raised any concerns with the consultant beforehand and were available for input if required.

Nurses took part in safety huddles took place at the start of each nursing shift, during which specific patient needs were discussed and any incidents that had taken place.

Nursing staff rotated between HDU and ITU, usually for three-month periods, although we were told by a senior nurse that some staff were less comfortable working on ITU and preferred working in HDU where there were less critical patients.

We saw that nursing staff, allied health professionals and the consultants communicated well to ensure that patients received the right level of care.

**Seven-day services**

The Critical care Units at the Royal Oldham Hospital were open 24 hours a day, seven days a week.

Staffing rota showed that nurse staffing levels were sufficient to meet national guidelines during out of hours periods.

There was a consultant present on ITU during the day and evenings (from 8am until midnight) on ITU and overnight an on-call consultant was available within 30 minutes, seven days a week.

Imaging and diagnostic services were provided during the working week and then on-call out of hours (after 5pm) and at the weekend.
There was a business case in place to increase staffing in physiotherapy and dietetics and to introduce staff in speech and language and occupational therapy to provide seven day services for the units.

Health promotion

There was an ongoing promotion in the hospital to ensure that as many members of staff as possible had received an annual flu jab. Staff that refused the jab were asked to complete a form, stating their reasons why.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We spoke to staff and observed that they had an understanding of the issues around consent and capacity of patients in critical care.

Staff sought consent from patients who were conscious and able to give consent, prior to undertaking any treatment or procedures and this was documented in the patients’ records.

The pharmacist told us that patient consent was sought to continue to prescribe their regular GP prescribed medicines.

Staff were able to make decisions about care and treatment in the best interests of the patient where the patient did not have the capacity to give consent. Best interest meetings took place at which all options were discussed. We saw that consultants spoke to relatives about the proposed care and sought their opinions.

We did not see any deprivation of liberty safeguard applications for patients on the unit. In most instances, the deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (the right to liberty) of the Human Rights Act 1998 and there was therefore no requirement for a deprivation of liberty safeguard application if the patient was receiving life-saving treatment on the Critical Care Unit.

There were assessments of mental capacity or delirium recorded in the patients’ records. The service used the Richmond Agitation and Sedation Scale (RASS), which measured the agitation or sedation level of a patient. A delirium prevention care bundle had been developed and this had been adopted by the Greater Manchester Critical Care Network.

Is the service caring?

Compassionate care

We observed staff treating patients who were present on the units with kindness and compassion. Staff took the time to interact with patients and treated them with dignity and respect. However, we observed that one patient in ITU who was distressed was not spoken to appropriately by nurses on two separate occasions. One nurse told the patient “Don’t be violent” and another nurse raised her voice at the patient and said, “Don’t be so nasty”. Our observations were relayed to the Matron.

All patients and visitors we spoke with (three patients and four family members or friends) gave us positive feedback about how staff treated and interacted with them.

One patient told us that the care they received was fantastic, but did feel that the high dependency unit was short-staffed. Another relative told us that the nurses were kind, friendly
and caring and that they had been treated with courtesy and that confidentiality had been respected.

Another patient told us that the nurses were caring and supportive; staff introduced themselves and regularly asked about pain relief if required.

We observed that when consultants were speaking to relatives about the patient’s ongoing care and treatment that they were taken to a private room where confidentiality could be maintained. Patients' privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around beds, with explanations given prior to care being delivered. The service did not participate in the NHS Friends and Family Test (FFT). They undertook their own local satisfaction surveys periodically though did not have a recent survey that they could show us.

**Emotional support**

Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives and we received positive feedback from relatives about their emotional needs being supported.

A spiritual care team was available on site to provide additional emotional support to relatives. Referrals to the team could be made by staff by telephone or via an online form and there were leaflets about the service available to visitors or patients.

Posters were displayed on site, with contact details for the hospital chaplaincy service.

Patients and relatives had access to the Patient Advice and Liaison Service (PALS), who were located in an office in the main hospital reception area should they wish to raise any concerns about care and treatment provided.

There was an onsite bereavement team and bereavement centre to support bereaved relatives. A comprehensive booklet covering a number of topics, such as viewing arrangements, organ donation, registering a death, the role of the Coroner, post-mortems, arranging a funeral and coping with grief, was available to bereaved relatives.

However, the service did not have a support group for patients following their discharge from hospital. This had been considered, but the numbers of surviving patients who may benefit from support was considered too large to arrange such a group if it was led by nursing staff. No alternative had been considered.

The service did not use patient diaries for those patients who were sedated and ventilated. Research has shown that patient diaries can help the patient to better understand and make sense of their time in a critical care unit and help to prevent depression, anxiety and post-traumatic stress.

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

Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and felt fully informed about their care and treatment plan and how long they were likely to have to stay on the unit and in hospital. They also told us that they had been seen regularly by a physiotherapist.

We spoke with the spouse of one patient, who told us that they had been seen by a Family Liaison Officer and were able to ask questions about the care and treatment of their relative. They felt confident to raise concerns and these had been addressed. The Family Liaison Officers were employed by the trust to liaise with complainants and discharge the duty of candour where required.

We observed that one patient had the proposed use of a special physio cushion explained to
them and was given the option of whether they wanted to use the cushion.

On occasions and when necessary, visitors were able to sleep overnight where there was a sofa bed available for their use in a room adjacent to the waiting room.

There was a kitchen on the unit for visitors to make snacks or hot drinks and this was shown to visitors by staff when they first came to the unit.

The units used a Critical Care Passport that was designed to give information to help staff to get to know the patient and their preferences. The patient or relative was able to give information, such as what they liked to be called, their job, people important to them, hobbies and pets, whether they wore glasses or hearing aids, usual sleep patterns and whether they would like eye masks and earplugs.

When patient treatment was withdrawn for the dying patient, a referral was made to the specialist nurse for organ donation (SNOD) and they attended the unit when required to talk to patient relatives about organ donation options and the patient’s wishes. Two staff nurses on the unit had expressed an interest in becoming link nurses for organ donation.

Is the service responsive?

Service delivery to meet the needs of local people

The Royal Oldham Hospital had been identified as a specialist hospital as part of the Greater Manchester “Healthier Together” proposals. This meant that it would be expected to carry out more emergency surgeries as a trauma unit and would therefore require an increased number of critical care beds to deal with the increased number of emergency admissions.

There were initial plans drawn up to build a new Critical Care Unit with 32 beds in a new extension to the main hospital building. The timescale for this to be built was two years. The new unit would merge the ITU and HDU units and allow flex between the numbers of level 2 and level 3 patients.

The plan was viewed upon as being the right solution to provide the right number of critical care beds for the local population going forwards. We were advised that staff input would be sought as to what would be required in the unit, for example, adequate and secure storage space.

Meeting people’s individual needs

There were adequate facilities in the critical care unit to allow access and use by disabled patients and visitors, including wide corridors.

Information leaflets about services, discharge and bereavement advice were available. Leaflets could be provided in different languages or other formats if requested, although they were not readily available.

Staff told us that they had access to a face to face interpreting service when required and this would be booked in advance whenever possible.

There was a critical care passport for patents in place that allowed patients and relatives to state any characteristics that may be protected under the Equality Act, such as any physical or learning disabilities and religion or spirituality and this informed staff of any adjustments that may need to be put in place for the patient.

Staff received training in dementia and how to care for patients who were living with dementia. There was a dementia link nurse in place. There was also a link nurse who specialised in patient delirium.

There was a critical care outreach team, who provided follow-up support to patients who had been discharged from the critical care unit. However, they did not cover all wards and did not provide a 24 hour a day, seven days a week service. They covered surgical wards, orthopaedics,
gynaecology, the labour ward and the medical assessment unit. There was a bereavement centre in the hospital and relatives and carers were offered support and advice in the event of bereavement.

The unit was not able to offer professional psychiatric support to patients, either on the unit, or after discharge and there was no follow-clinic offered to patients who may require such a service. The service did not keep patient diaries to enable patients to see and process their stay in the unit when they had recovered.

**Access and flow**

People could access the service when they needed it. The service did not ring-fence any beds for emergency admissions. If the unit was full, patients may need to be transferred to theatre recovery or elective admissions. Patients may be kept in theatre recovery after surgery until a bed became available.

Bed management meetings took place within the hospital throughout the day and these included the availability of critical care beds. We were told that if there were not enough nursing staff available on shift to staff the occupied beds at a ratio of 1:1 in ITU and 1:2 in HDU, then preparations were put in place to close empty beds to admissions until the nursing staffing ratio met the required levels.

Elective surgeries were cancelled infrequently because of a lack of beds in critical care. Over the last 12 months, elective surgery was cancelled in 30 cases because of the lack of an available critical care bed. This amounted to 0.13% of all elective admissions.

**Bed occupancy**

Between August 2016/17, The Pennine Acute Hospitals NHS Trust has seen adult bed occupancy stay relatively consistent. October 2016 to December 2016 saw a slight increase, but since then occupancy levels have stayed fairly stable month on month. This is about the same as the England average throughout the period, falling below as of August 2017.

**Adult Critical Care Bed occupancy rates, The Pennine Acute Hospitals NHS Trust.**

![Graph showing adult critical care bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
Delayed discharges

For the intensive therapy unit at Royal Oldham Hospital, there were 2928 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 3.3%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 3.1%.

For the high dependency unit at Royal Oldham Hospital, there were 2928 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 7.6%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 8.5%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers

For the intensive therapy unit at Royal Oldham Hospital there were 383 admissions, of which 0.5% had a non-clinical transfer out of the unit. Compared with other units this unit was within expected limits. The figure in the 2014/15 annual report was 0.6%.

For the high dependency unit at Royal Oldham Hospital there were 734 admissions, of which 0.1% had a non-clinical transfer out of the unit. Compared with other units this unit was within expected limits. The figure in the 2014/15 annual report was 0.6%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-delayed out of hours discharges to the ward

For the intensive therapy unit at Royal Oldham Hospital, 3% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was within expected limits. The figure in the 2014/15 annual report was 2.4%.

For the high dependency unit at Royal Oldham Hospital, 8.4% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was worse than expected. The figure in the 2014/15 annual report was 6.3%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Summary of complaints

Between June 2016 and May 2017 there were five complaints about Critical Care services (0.6% of all complaints).

The trust took an average of 98 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 here were two complaints still open and yet to be completed.

The five complaints related to clinical treatment (2), end of life care (2) and access to treatment or drugs (1).

Royal Oldham Hospital: Four complaints.
We were unable to review any ongoing complaints files on the unit, as we were told that the last complaint was received in August 2016 and this had been closed in December 2016. We were told that this related to a family who had misunderstood information that was given to them and lessons were learned around communicating things properly to patients and relatives and ensuring that they had understood.

**Is the service well-led?**

**Leadership**

The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care

Since our last inspection in February 2016, the four hospitals in the trust had been divided into three care organisations: North Manchester, Bury and Rochdale, and the Oldham Care Organisation. Each care organisation was led by an executive committee, comprising a medical director, managing director, director of nursing and director of finance.

The critical care units were part of the Division of Surgery, led by a divisional clinical director, managing director and director of nursing. The division was divided into four directorates and critical care formed the Clinical Support Services Directorate. This was led by a directorate manager, clinical director, assistant director of nursing and a directorate manager for critical care units across three hospitals.

Staff reported that they thought that the care organisation leadership team was excellent, that they were visible in the hospital and moving things forward.

Staff reported that things had improved since there was an on-site critical care senior management team and that issues could be escalated and dealt with more quickly. There was more understanding of the issues affecting each individual unit.

The senior nursing team undertook regular walkabouts within the hospital where they could familiarise themselves with staff and wards and staff had the opportunity to raise concerns with them without having to leave the ward.

However, at a local level, there was no medical leadership on the HDU from 6pm to 8am, although this was an improvement since our last inspection when there was no medical leadership at all on HDU. During the day there were medical leads on HDU and ITU. The eight critical care consultants were led by a lead consultant.

The nursing and care staff on the Critical Care Units were led by a matron who was supported by sisters and charge nurses.

Pharmacy and physiotherapy staff told us that their direct leadership was excellent and that they felt well supported in their role. The clinical physiotherapy lead was described as visible, proactive and innovative.

**Vision and strategy**

The trust had a vision for what it wanted to achieve.

The trust had a vision and a set of values in place. The trust vision was to be “A leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.”

The trust values were that the staff are “Quality driven; responsible and compassionate.” Posters displaying the trust vision and values were displayed around the hospital and staff were aware of what they were.
The trust also had a set of corporate priorities and strategic goals for 2016/17 and they could be found on the trust website.

In addition there were priorities for 2017/18 and a Quality Improvement Strategy 2017-2020 for each care organisation.

Following our last inspection the trust had developed and published an improvement plan to enable patients to receive safe, reliable, compassionate and high quality care, whatever day of the week, whatever time and whether in or out of hospital. The improvement plan was focussed across improving six key areas: fragile services; quality; risk and governance; operations and performance; workforce and safe staffing and leadership and strategic relations.

Critical care had been identified as one of the fragile services. The critical care improvement plan pledged to stabilise staffing, including consultant middle grade cover for HDU at Royal Oldham Hospital and to ensure that the nursing and AHP workforce was adequate across the critical care units. It also pledged to determine the requirements for critical care outreach and safe response at night and weekends.

Some staff we spoke to were unaware of the critical care improvement plan or its contents.

**Culture**

A positive culture that supported and valued staff, creating a sense of common purpose based on shared values was not in place.

Several staff reported that they did not feel supported by their manager. We were told that morale was low and that this impacted on staff willingness to "go the extra mile". We were told that there were no team meetings conducted. There was a general perception that, when staffing levels were good, staff would be immediately shifted off the unit to support staff at Fairfield General or another ward within Royal Oldham Hospital and this put them under added pressure and made them feel less valued.

Staff retention and the number of new staff was also described as an issue as it affected the skill mix. We were told that approximately one third of the nursing staff were new and this put pressure on the practice based educators. They were described as not being very visible on the unit.

Staff also told us that, since Salford Royal NHS Foundation Trust, took over the leadership of the trust, that there was a general feeling of “it is Salford’s way or no way”. Staff said that they felt as though the other trust’s policies and procedures had been imposed upon them and they did not always match the model of care delivered by Pennine Acute and that some of their old policies and procedures were better than the new ones.

**Governance**

The service had developed a systematic approach to continually improving the quality of its services. However, these systems were not yet fully implemented.

At our last inspection, the new critical care directorate management triumvirate had developed papers outlining the investments required by the trust to address the current shortfalls in meeting the national critical care Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards . The business cases were still in place at the time of our latest inspection, but there appeared to be no firm timetables or action plans in place for achieving the proposals. There had been the recruitment of a matron to the units, three middle grade doctors had just started work and one supernumerary nursing shift co-ordinator was in place. However, there had been little progress in achieving the other recruitment proposals outlined in the business cases.

Critical Care Directorate meetings were planned to be held on a monthly basis. The directorate meetings were attended by senior critical care staff from across the three hospitals with critical care units, such as matrons, senior nurses, consultant leads and the directorate manager, supported by the ICNARC clerk, physiotherapist and practice educator.
The minutes we reviewed showed that there was an agenda that covered governance (the risk register, incidents and complaints, infection control, mortality and morbidity minutes and outreach services); HR (sickness, mandatory training, appraisals and vacancies); finance and performance (agency and locum spend and organ donation); job planning; transformation (business cases for nursing, AHP and medical, “healthier Together” programme and the improvement plan) and equipment.

There was evidence that issues raised in the directorate meetings were escalated and discussed at divisional meetings and that questions arising from that meeting were passed back for response. The AHP business case had recently been presented at a management board meeting for ratification.

An escalation process flowchart was being developed by the trust in line with the organisational structure.

We reviewed the monthly critical care divisional mortality reports for the last three months for both HDU and ITU. The purpose of the report was to provide a performance update, highlighting the actions being reviewed and agreed by the Divisional Clinical Governance Committee. Every action on the report should be monitored and reviewed by the Divisional Governance Committee and each action should be completed within one month and closed at the next meeting.

However, the critical care divisional mortality reports showed that, where actions required relating to a death had been added to a report, there were no due dates for completion, no action lead or supporting managers were given, there was no narrative about progress of actions and no indication as to whether actions had been completed.

Management of risk, issues and performance

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not consistent.

There was a critical care risk register in place. However, the risk register had no review or completion dates contained within and no assurances or gaps in assurances completed and the likelihood and impact did not match up to the overall initial risk in most instances. For example, the risk of patients who were admitted to HDU when there was no critical care consultant intensivist on duty, being admitted inappropriately or treated inadequately, had a likelihood score of four and an impact score of four (overall risk score of 16). However, the opening position risk score on the register was stated as 11.

There was a single risk register for all the critical care units within the trust that outlined the risks affecting each individual unit, or risks which were common for all the units. The risk register showed that, at the time of our inspection, there were 20 risks that had been identified and that may impact on the critical care units at Royal Oldham Hospital.

Risks included the lack of consultant leadership out of hours on the HDU; the failure to comply with required bed spaces for critical care units; the lack of a supernumerary shift leader on HDU; the lack of follow-up clinics for patients and the potential for demand to exceed capacity, leading to patient transfers to another unit.

Senior management met twice a month to discuss what needs to be included on the Divisional Care Organisation risk register and individual directorate registers.

Some concerns had been raised with regards to the risks on the critical care register that should be on the Care Organisation risk register.

We saw evidence that actions were taken in response to performance and risks, for example, when performance in mortality rates worsened on HDU, a review was undertaken to discover the reasons for this and make recommendations to improve the situation. Further safeguards had been introduced to minimise the risk of inappropriate admissions overnight and they were perceived by the lead consultant to have made an impact though not enough time had passed since their introduction to produce a meaningful audit. Arrangements had been drawn up to deal
with an anticipated flu epidemic.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The units were required to submit data on a regular basis to the Intensive Care National Audit and Research Centre (ICNARC). This ensured that the quality of the units and comparison with similar units could be monitored and analysed. The data was available in the public domain.

In order to ensure that performance data was accurate, valid, reliable, timely and relevant and that the data was submitted as required, there were ICNARC (or audit) clerks employed by the unit. Their responsibility was to collect and collate patient and treatment data and submit it to ICNARC in the correct format. They also audited and analysed data for use in other internal reviews, such as the review on mortality conducted by the consultant leads.

There was a secure electronic medicines prescription system in use on the unit. Patient records were not electronic, but there was a plan in place to introduce an electronic patient record system in the near future. There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet.

However, a common complaint was that IT systems were very slow. Particular reference was made to the pathology results system where staff said that they had to wait an unreasonable amount of time to get into the system and obtain results during busy periods and this had the potential to impact on patient safety where timeliness of receiving results and administering the right medicines was critical to the well-being and recovery of the patient.

**Engagement**

The trust had a number of engagement activities for staff with regard to the improvement plan. One such activity was called “1000 Voices” at which staff were invited to listening events and able to state what worked well and did not work well and make suggestions for improvements. However, staff reported that they did not have the time to attend the events. They also told us that they had received little feedback following the events and had not seen any changes made in the organisation as a result of their suggestions.

There were a range of communications to staff to advise them of ongoing changes and improvements, such as newsletters, Monday Message email and staff awards were in place to celebrate successes.

At unit level, the Matron produced a weekly email for staff. However, the matron and nurses told us that nursing and care staff did not have team meetings. We were told that it had proved difficult to organise these because staffing levels at the required level needed to be maintained on the wards.

Managers told us that, in the process of designing and building a new critical care unit at the hospital that staff would be involved and consulted upon about the design and layout of the unit.

With regard to public engagement, there was a range of information in leaflet form and on the trust website about the critical care services.

The service did not participate in the Friends and Family Test, as this was generally conducted with patients when they were discharged from the hospital from another ward, having been stepped down from critical care.

We were told that surveys with patients and carers or relatives were conducted. There was no recent survey for us to look at to gauge public feedback.
The critical care service did not have patient and family support group to enable them to gain support and share experiences.

**Learning, continuous improvement and innovation**

The trust had short and long term plans in place to sustain and improve the critical care unit at The Royal Oldham Hospital. There were business cases in place to recruit medical, nursing and therapy staff, so that the service would meet critical care Guidelines for the Provision of Intensive Care Services (GPICS) Core Standards where possible. In the long term, there were plans to build a new 32 bedded unit on the hospital site in an extension to the main hospital building. However, there had been no consideration as to how a unit of this size would be staffed, given the current slowness and difficulties in recruiting appropriate staff to the existing unit.

There was evidence that the unit was learning from internal and external reviews carried out. For example, there was an improvement programme in place following on from the last CQC inspection to address the concerns raised. The consultants on the unit had carried out a mortality review on the high dependency unit following on from the last CQC inspection because mortality rates on the unit had actually worsened since partial intensivist cover was provided to the unit. The review looked at when patients were admitted to the unit, whether it was out of hours or when there was critical care consultant cover; whether the admission was appropriate and whether data was of a satisfactory quality. A number of recommendations came out of the review, including expanding the intensivist cover to evenings and overnight.

In terms of innovative practice, a physiotherapist on the unit had won a staff award, having introduced the Chelsea Critical Care Physical Assessment Tool (CPAX).

A retired colleague of the unit was involved in running the critical care symposium in Manchester and donated £50,000 funds from the symposium for the good of the unit. The money was used to buy a number of pieces of equipment, such as a transoesophageal echo probe.
Maternity

Facts and data about this service

Pennine Acute Trust has 133 Maternity beds, split across two sites, North Manchester General Hospital and The Royal Oldham. Both hospitals provide obstetric services with co-located birth centres.

The Royal Oldham Hospital has 70 beds; 24 antenatal, 29 postnatal and 12 labour rooms on the consultant led unit including one pool room and one high dependency unit. The midwifery led birth centre at The Royal Oldham has five beds including three with a birthing pool.

Between April 2016 and March 2017, there were 8,997 deliveries at the trust.

A comparison between the number of births at the trust and the national totals during this time period is shown below.

(SOURCE: HES - Deliveries (01/04/2016 - 31/03/2017)
A profile of all deliveries between April 2016 and March 2017 is shown below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (April 2016 to March 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pennine Acute Hospitals NHS Trust</td>
</tr>
<tr>
<td>England</td>
</tr>
<tr>
<td>Deliveries (n)</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Multiple</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
</tr>
<tr>
<td>Under 20</td>
</tr>
<tr>
<td>20-34</td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40+</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
</tr>
</tbody>
</table>

Note: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

(Source: HES - Deliveries (01/04/2016 - 31/03/2017)
Mandatory training

The service provided mandatory and obstetric specific training in key skills to all staff and most staff had completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services as well as those working in maternity services)

Medical and dental staff in the Women’s and Children’s division met the 90% target for mandatory training compliance for three modules only. Information provided during the inspection showed 96% of medical staff at this hospital site had completed their mandatory training.

Basic life support training had the lowest compliance levels with only 60% of eligible medical and dental staff having been trained. This has improved at the time of our inspection in October 2017 and, 82% of medical staff were up to date with basic adult life support training.

One of the practice education midwives was a trainer for basic life support. This had been introduced as part of the Practical Obstetric Multi-Professional Training training day. This training was compulsory for all midwives and medical staff in the obstetric department. Compliance with this training was 81% for medical staff. The compliance rate for midwifery staff was not provided.

An external neo-natal life support training course was being reviewed by the practice education midwives. In the interim of this being available an in-house course had been developed and delivered to staff.

Training in the recognition, assessment and management of sepsis had been included as mandatory for all midwifery and medical staff. 47% of medical staff who required this training had completed it. The number of midwives trained was not provided.
Nursing and midwifery staff in the Women’s and Children’s division met the 90% target for mandatory training compliance in five modules. Both waste management and infection prevention (non patients) achieved 100% compliance, however the requirement for eligible staff members for these modules was very low with only one and two members respectively eligible for training in these areas.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Since the last inspection a team of three midwives had been appointed as practice educators. Their main role was to support staff to complete their mandatory training, develop specific training packages, design competence assessment tools and audit practice to identify learning needs.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However midwives did not receive safeguarding supervision.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division is shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services as well as those working in maternity services)
The 90% target was not met for any of the safeguarding modules by medical and dental staff in the Women’s & Children’s division at the trust. The target for level 2 children’s training compliance was almost achieved with 89.5% compliance which equated to 145 of the 162 eligible staff members completing the training.

Nursing and midwifery staff in the Women’s & Children’s division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There was no system to include a record on a patient’s information that a check to identify any safeguarding concerns had been completed. Midwives spoken with stated this would always be checked on admission; however agreed there was no documentation of this check within the patients’ records.

We saw women were spoken with alone if there were concerns regarding domestic violence or any other issues of concern about their partner.

There was a system for following up women when they failed to attend an appointment. The first
time a woman failed to attend they received a telephone call, the second time a letter was hand delivered by the community midwives. There was no more further follow up after a third failed appointment unless there were known concerns.

There was one specialist safeguarding midwife who was part of the general safeguarding team for the trust. This meant community midwives managed patients with complex social needs along with the rest of their caseload of around 120 patients. They could ask for advice and support from the specialist midwife.

There was no system of safeguarding supervision for the community midwives. One of the underlying principles of the Intercollegiate Document 2010 is that those working with children and young people or parents should include clinical governance and supervision as part of their learning. There were plans to implement this however no timescale was provided by the trust.

The community midwives used the local children’s centres as their base. This meant there was opportunity to discuss any concerns they might have about a mother or babies.

Midwives and medical staff received training in the recognition and management of female genital mutilation.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

All areas of the maternity unit we visited were visibly clean and tidy.

We saw staff washing their hands and using the hand gel available between interactions with women. Staff reminded visitors to use the hand gel which was available in all areas of the service.

Hand hygiene audit information was displayed on the boards at the entrance to the various units. This showed 100% had been achieved for September 2017 on the postnatal ward.

Personal protective equipment was provided and we saw staff using this appropriately. This was audited on a monthly basis and the results displayed on the ward board. On the postnatal ward the previous month the service achieved 93% in the audit. We were told the issues that led to less than 100% compliance would be discussed at the safety huddle.

Managers had carried out an investigation with the infection prevention and control manager due to a rise in sepsis cases in maternity services. Information provided by the trust showed this had risen to 5% of births in May 2017 from 2% in April 2017. They had found the classification of sepsis had been used when this was not the actual diagnosis. A staff education programme had taken place. This had reduced to 1% in September 2017.

There was a system in place to clean the birthing pools. The temperature of the water was checked; however records showed this was not recorded clearly or consistently. This had been raised at the last inspection and remained unchanged.

Environment and equipment

The service had suitable premises and equipment however not all equipment was well looked after. Some of the equipment used in an emergency had not been checked at a frequency that was in line with the trust’s policy. This included resuscitation equipment for women and babies.

The daily checks for the adult resuscitation equipment were completed for those we reviewed. However the weekly check when the contents of the sealed trolley should be examined had not been done in all areas. In two units records showed this had not been completed for two and three weeks.

Staff in all areas reported they had enough equipment to meet the demands of the service. This included monitoring equipment such as cardiotocography (used for monitoring the fetal heart
rate) doplar and blood pressure monitors.

An electronic fetal monitoring system had been introduced the week of the inspection. Staff had received training to use this equipment and specific midwives had been identified to provide ongoing support during its implementation.

The equipment in theatres, such as the anaesthetic equipment, had been checked. We saw staff carrying out routine equipment checks prior to surgery taking place.

Improvements had been made to the facilities for bereaved parents. The area now provided a more homely environment.

Assessing and responding to patient risk

The Maternity Early Warning Scores assessments to detect deterioration in a woman’s condition were not completed in the prescribed timescales. Women did not always receive a medical review when their assessment identified this was required.

At the last inspection concerns were raised about early warning scores assessments not being completed correctly and patients whose scores indicated their condition was deteriorating were not always appropriately escalated for medical review. At this inspection we reviewed 20 patient records and found 10 were incorrectly completed. This meant these women did not have their Maternity Early Warning Scores completed within the timescales set out in the policy, including if the previous score showed they were at risk of deterioration. We reviewed five records on the labour ward and these were fully completed and deteriorating patients had been escalated appropriately.

An audit of 126 women’s maternity early warning score records was completed in September 2017. This showed improvements in all areas with “observation frequency increased” going from 50% to 90%. However none of the measures met the trust’s 100% target.

A trust wide action plan had been developed to implement a maternity early warning score train staff on its use and monitor the effectiveness. This had been implemented following a coroner’s report in August 2016. We found some actions had not been implemented effectively and therefore the expected improvements were not found. This was raised with senior managers during the inspection.

Information provided during the inspection showed 54% of staff had completed an on-line training course about the management of deteriorating patients. This included acute illness management for patients who were in the high dependency unit. We saw only staff who had completed this course were allocated to work in that area. The practice education midwives were working with the critical care educators to develop maternal acute illness management training.

A sepsis screening tool had been introduced and we saw this had been used when a patient’s observations indicated they may have sepsis.

In the triage area women were assessed on arrival therefore any immediate risks were identified. The women’s risk status was documented on a board which included early warning scores and outcome of medical reviews.

We reviewed four World Health Organisations surgical safety checklists and two had not been completed fully. During an observation in theatre the procedure was not completed in line with guidance; staff did not always carry out the checks before ticking the check list.

There was a system on the postnatal ward for every woman being seen every two hours. This was to ask them about their comfort and any needs they had and check the baby was comfortable (this is known as intentional rounding).

There were delays of between three and five days in receiving the results of investigations in the antenatal clinic. This included blood results and those for microbiology.

The information board in the staff office on the labour ward had been changed to include the risk assessment status of every woman. This included their risk of venous thrombo-embolism, any
safeguarding concerns and signs of deterioration. This meant all midwifery and medical staff could quickly see the risk status of all women on the ward.

Staff were observed to follow the “fresh eyes” principle for checking cardiotocography readings. This is a buddy system for cardiotocography interpretation so that ‘fresh eyes’ can detect any potential problems during labour.

In the patients’ records we reviewed on the labour ward an assessment of the woman’s condition was included in the documentation when the care was handed over to another midwife.

**Nursing staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in maternity and obstetrics and gynaecology for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Maternity WTE in post</th>
<th>Maternity WTE planned</th>
<th>Obstetrics &amp; Gynaecology WTE in post</th>
<th>Obstetrics &amp; Gynaecology WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>337.71</td>
<td>346.87</td>
<td>54.03</td>
<td>59.35</td>
</tr>
<tr>
<td>January 17</td>
<td>333.31</td>
<td>346.87</td>
<td>55.67</td>
<td>60.35</td>
</tr>
<tr>
<td>February 17</td>
<td>331.45</td>
<td>346.87</td>
<td>56.87</td>
<td>61.88</td>
</tr>
<tr>
<td>March 17</td>
<td>329.45</td>
<td>346.87</td>
<td>55.73</td>
<td>63.70</td>
</tr>
<tr>
<td>April 17</td>
<td>331.32</td>
<td>346.87</td>
<td>54.85</td>
<td>63.70</td>
</tr>
<tr>
<td>May 17</td>
<td>329.15</td>
<td>346.87</td>
<td>54.85</td>
<td>65.21</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 5.0% for nursing and midwifery staff in maternity and 8.5% in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

At the inspection we were told there was a vacancy rate of 6.4 whole time equivalent (WTE) posts on the postnatal ward. There had been an increase of 2.64 WTE band 3 posts recently which had improved the overall staffing on this ward.

We were informed 84 midwives had been recruited at the trust in the past 12 months. Staff and managers in the maternity services told us the increase in midwives had led to improved staffing numbers and there was continuing recruitment.

Three trainee nurse associate posts had been developed. This was a new role designed to bridge the gap between health care assistants and registered midwives.

A recent staffing paper had been completed which revised staffing establishments in the wards and departments. Managers and staff were aware of the changes.

There was no midwife sonographer as they were based at North Manchester General Hospital. There were plans for this to change.
Turnover rates

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.3% for nursing and midwifery staff in maternity and 1.4% in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017 the trust reported an average sickness rate of 5.9% for nursing and midwifery staff in maternity and 4.9% in obstetrics and gynaecology, both being above the overall trust target of 4.6% for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

Rotas on the antenatal and postnatal wards showed there was a high use of agency staff to ensure staff numbers were sufficient to meet the needs of patients. This included two of five midwives being bank staff on three nights in one week.

We were told, when possible, on all wards regular agency staff were used to aid consistency for patients and staff.

Midwife to birth ratio

Senior managers told us the birth to midwife ratio was 1:27.8. This met The Safer Childbirth Minimum Standards for the Organisation of Delivery of Care in Labour (October 2007) recommendations of 1:28.

Information on the board in the labour ward showed one to one care in labour for 96.9% of births in September.

The band seven midwife on the labour ward was supernumerary. This met with staffing guidance.

On the midwifery led birth unit there were two midwives and one health care assistant on all shifts. The midwives of an appropriate grade to ensure they had the experience to work on this unit.

The staffing skill mix for community midwives meant there was a band seven midwife as team leader for each of the nine teams. They had a reduced caseload of around 80 to 90 patients and had one day for management activities per month.

The community midwives told us four midwives were available to support home births and a system was in place to re-deploy staff should they be called out at night. We saw an on-call pathway which detailed when midwives would take a break from work if they had been called out during the night. This also gave the option to request assistance from the second midwife on call.
Medical staffing

The trust has reported the following planned and actual staffing figures for medical staff working in obstetrics and gynaecology for the period December 2016 to May 2017. Under the service of maternity – the trust has no records for medical staff figures; they all fall under obstetrics and gynaecology.

<table>
<thead>
<tr>
<th>Month</th>
<th>Obstetrics &amp; Gynaecology WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>49.60</td>
<td>48.50</td>
</tr>
<tr>
<td>January 17</td>
<td>49.28</td>
<td>48.50</td>
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<tr>
<td>February 17</td>
<td>49.28</td>
<td>48.50</td>
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<tr>
<td>March 17</td>
<td>49.28</td>
<td>48.50</td>
</tr>
<tr>
<td>April 17</td>
<td>49.28</td>
<td>48.50</td>
</tr>
<tr>
<td>May 17</td>
<td>49.28</td>
<td>48.50</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of -3.8% indicating an over establishment for medical staff in obstetrics and gynaecology.

- The Royal Oldham hospital has an over establishment of medical staff within obstetrics and gynaecology and therefore has an average vacancy rate of -12%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 1.3% for medical staff in obstetrics and gynaecology.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 3.1% for medical staff in obstetrics and gynaecology which is better than the overall trust target of 4.6% for sickness rates.

- The Royal Oldham – average of 3.7%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

The reliance on locum staff was one of the risks discussed by senior medical personnel. They were using locums to cover long term sickness in two posts. However recent recruitment would reduce the overall use of locum staff by January 2018.

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average, whilst the proportion of junior (foundation year 1-2) staff was slightly higher.

**Staffing skill mix for the 81.5 whole time equivalent staff working in Maternity Services at The Pennine Acute Hospitals NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Consultant cover on labour ward

Medical staffing rotas received for October 2017 showed a consultant obstetrician on duty Monday to Friday with a registrar on duty Saturday and Sunday. A consultant was on call to attend the unit if required at all times.

A consultant anaesthetist was available on the labour ward daily between 8am and 6pm. Outside these times a middle grade doctor was available with an on-call anaesthetist contactable should they be required.

Records

Staff kept appropriate records of patients’ care and treatment. Written entries in patient records we reviewed were legible, signed and dated.

Not all patient records were securely stored in some areas of the maternity services we visited. Lockable records trolleys were provided; however these were left open and records left on top. In most areas patients’ records were kept in the staff office.

The community midwives had a paper based record system which led to delays in information being available to other areas of maternity and health services. The midwives had to input the personal information when they were in the office and this was done within five days of the patient consultation. This meant no-one else who may see the patient in that time had access to these records. This had been identified as a risk and escalated to senior managers.
Medicines

Medicines were appropriately prescribed, administered, recorded and stored within the service. Electronic prescribing was in place for medicines in the maternity unit. We saw this was easy to use and included an alarm mechanism to alert staff if medicines were overdue. Staff told us there was no way to change this alerting system and it was synchronised to the prescribing time and not the administration time. This meant it did not always give a true picture of delays in administration.

On the postnatal ward staff told us there could be delays in the administration of intra-venous antibiotics. This was due to a shortage of staff trained and competent to carry out this task. Systems were in place to reduce the delays, incidents were raised due to a delay in patient care and there were plans to better manage this in the future.

Incidents

The service managed patient safety incidents well.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Maternity.

(Source: Strategic Executive Information System (STEIS))

During the inspection we were told of an incident which had occurred several years earlier but had recently been reported to the trust. This was a retained object which had been classified as a never event. An investigation into this was underway.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in Maternity which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 2 maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)
- 2 maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)
- 1 treatment delay meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

The system for the management of incidents had improved since the last inspection. There was a clear procedure for the reporting, allocation, investigation, and sharing of learning. This included weekly meetings to discuss all incidents in maternity services, including progress on investigations. There was no backlog of incidents waiting for investigation which was a much improved situation than at the last inspection.

We were given examples of where changes of practice had occurred following serious incidents.
This included additional training for staff by the practice education midwives and additions to
documentation. However staff we spoke with in the triage unit could not tell us of any changes in
practice following a serious incident in the same unit at North Manchester General Hospital. The
action plan did include changes across the trust.

The new system of a weekly meeting to review all incidents meant any themes were recognised.
We were given an example of a change to documentation when a theme of retained pessaries
was identified. The outcomes of incidents were shared with staff through the safety huddles and
displayed on ward boards.

The number of incidents per month was displayed on the board to the entrance of each ward.
Ward managers were aware of any themes in their incident reports and discussed where these
had been identified and actions taken.

Safety thermometer

Information for the maternity safety thermometer was collected on the wards and departments.
However this had not been submitted to the NHS safety thermometer database since October
2016. This meant themes and trends could not be identified. We were told this information was
collated however an administration change had resulted in it not being submitted. This was not
displayed in all relevant areas of the maternity units.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its
effectiveness.

Guidelines were available online. Staff knew how to access these and those we reviewed had
been updated and referenced the latest national guidance.

Proformas for the management of emergencies were present in all the rooms on the labour ward.
This included the management of post-partum haemorrhages and shoulder dystocia.

We observed senior medical staff referring to obstetric guidelines when they were advising less
experienced doctors.

Pathway review meetings took place to ensure the journey for antenatal patients through the
maternity services was effective. Managers from various maternity departments attended these
meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. However
there was a lack of food and drinks available in the antenatal clinic. A water fountain was
available however the dispensing machine with other drinks and snacks had not been replaced
when it broke down three months previously. Women and partners could have long waits in this
clinic.

There had been a re-assessment for the UNICEF Baby Friendly Initiative on 4 October 2017. The
standard for the award of level three had not been met. Actions were being taken for re-
assessments in six months.

Parents gave us examples of how staff had patiently helped them to feed their babies. We were
told there was no pressure to breast feed and patients were assisted with their babies whatever
method they chose. The breast feeding rate was 69%.

There were two lactation consultant midwives and two full time infant feeding supporters who
were band two staff. They supported parents to feed their babies, giving advice and one to one care.

A frenulotomy service was available which was run by lactation consultant midwives. A frenulotomy is the removal of a small fold of tissue that prevents the tongue from moving correctly. There was a three week waiting list; however should a baby need this urgently it would be carried out prior to the baby being discharged.

**Pain relief**

Pain relief was not always provided to women when they needed it on the postnatal ward.

The patient experience midwife had identified some delays in the administration of pain relief when raised as complaints by women. Managers told us not all staff were reporting this as an incident which should be done.

We saw a record in one woman’s notes, on the postnatal ward, that pain relief had not been administered overnight. An apology had been given to the woman by staff at the time.

On the postnatal ward we observed women and partners reminding staff that pain relief had not been received as requested. Staff were then quick to respond. Other women told us they had to wait for pain relief.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. However we found one measure was above the England average and this had not been identified or action taken.

**National Neonatal Audit Programme**

In the 2016 National Neonatal Audit the trust’s performance was as follows:

**The Royal Oldham Hospital:**

**Do all babies of less than 32 weeks gestation have their temperature taken within an hour after birth?**

There were 98 babies born at <32 weeks included in this audit measure for the unit. 98% of these babies had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

**Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 190 eligible mothers identified for inclusion in this audit measure for the unit. 85% of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

(Source: [National Neonatal Audit Programme](https://www.rcpch.ac.uk), Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

Between January and December 2016 the total number of caesarean sections and the standardised caesarean section rates for both elective and emergency sections were all similar to
expected.

In relation to other modes of delivery between January and December 2016 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Pennine Acute Hospitals NHS Trust (The) (RW6)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Pennine Acute Hospitals NHS Trust (The)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>2,453</td>
<td>27.0%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>864</td>
<td>9.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>5,753</td>
<td>63.4%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>9,080</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans  
²Includes forceps and ventouse (vacuum) deliveries  
³Includes breech and normal (non assisted) deliveries

The trust had a slightly higher rate of non-interventional deliveries than the England average.  
(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

### Maternity active outlier alerts

As of 24th August 2017 the trust has no recorded Maternity outliers.  
(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Prior to the inspection the trust was confirmed as a maternity outlier for emergency caesarean sections. A CQC outlier is a service which lies outside the expected rate of performance. Information provided by the trust showed the rate of emergency caesarean sections was around 20% of total births for August and September 2017. This rate had been worse than the England average since October 2016.

### Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2016 MBRRACE audit and their stabilised and adjusted extended perinatal mortality rate (per 1,000 births) was 5.90 (5.02 to 7.39). The comparator group was 6.44.  
(Source: MBRRACE UK)

Patient outcomes data was presented on dashboards. These were displayed in most areas of the maternity services; however they were not up to date in all areas. Staff we spoke with, including senior managers, said there were IT issues which were preventing them from accessing the dashboards online. This had been escalated.

The homebirth rate was 3% which was above the national average. (information provided by community matron)

A report about the activity in the birth centre was completed for April 2016 to March 2017. This
documented the outcomes for women who had attended this area including the mode of delivery. A review of the reasons for transfer to the labour ward and the postnatal ward was included. Information showed 70.7%- 76.6% of all low risk women admitted to the Birth Centre in labour, birth on our Birth Centre. In the report it is stated “our figures of 23.3% - 29.3% transfer rate to the Labour Ward of women in labour are well below the national average”.

**Competent staff**

The majority of staff were competent for their roles.

At the last inspection concerns were raised about midwives who assisted in obstetric theatres for caesarean sections without their training being up to date or their competence assessed. At this inspection qualified theatre staff were used for elective caesarean sections, however midwives still provided assistance in theatre with some emergencies. This had occurred 17 times between 19 July 2017 and 19 October 2017 which was an average of 1.3 times per week. All staff who were able to scrub had undergone a competency assessment and the evidence folder was kept on the labour ward. A theatre paper was submitted which requested that main theatres supported the day to day running of maternity theatres. This was currently going through the governance of the organisation for approval.

**Appraisal rates**

Between June 2016 and May 2017, 88% of staff working within the obstetrics specialty within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 90%.

The 88% appraisal rate applies to nursing and midwifery registered, administrative and clerical and additional clinical services staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Royal Oldham Hospital 85% had received an appraisal.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

Midwives told us they worked within their competence if they moved to a unit they were not familiar with due to staffing shortages. Examples were given of where two or three staff would move around to ensure the midwife moved to the labour ward had the competence to work there safely.

Simulation training for obstetric emergencies such as major haemorrhage and sepsis was provided.

Information provided by the trust showed 92% of medical and midwifery staff had completed training and competence assessment in CTG. This included 95% of midwives and 96% of community midwives.

We saw that midwives who were new to the trust worked in a supernumerary capacity alongside an experienced midwife until they were competent to work alone.

A buddy system for new midwives was in place. They told us they felt supported and could ask for support, assistance or advice whenever it was needed.

Since the recognised system of the supervision of midwives had ceased no alternative system for supervision had been developed.
Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

We observed midwifery and medical staff to discuss patient care and treatment professionally, requesting each other’s opinion and agreeing plans for care.

There was a handover of patient care between shifts which included midwifery, obstetric doctors and anaesthetists as appropriate to the activity of the day. Relevant patient information was shared including risks and any additional emotional or social complexities.

There were multi-disciplinary antenatal clinics held. These included specialist medical clinics such as diabetes when specialist midwives, nurses, dieticians and doctors saw the patients. Managers told us there were plans to develop more shared care clinics such as mental health and hypertensive disorders.

Seven-day services

Sonography services were available Monday to Friday 8am to 5.30pm. There were plans to extend this to evening and weekend appointments.

There were no antenatal clinics held in the evenings or at weekends.

Health promotion

There had been a rise in missed anti-D appointments due to patients not attending. There had been over 20 in July 2017 which had reduced to over 10 in September 2017.

Health promotion information was present in the units. This included support to stop smoking and reduce alcohol intake.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Written consent was obtained from women prior to surgery and recorded clearly.

Staff knew how to support patients experiencing mental ill health.

Midwifery and medical staff were given information about mental capacity during their training. However information provided by the trust showed that 8% of medical staff had completed this training. This training included best interest decision making, the assessment process and how to record the decision. Those we spoke with knew their responsibilities in terms of ensuring women had capacity to consent prior to invasive procedures.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff assisting and supporting patients and their partners in a caring and respectful manner. They treated them with dignity and respect.

When staff were speaking to each other about patients they were respectful in their language.
Friends and family test performance, percentage recommended (antenatal)

Between July 2016/17 the trust’s Maternity Friends and Family Test (antenatal) performance (% recommended) was generally in line with the England average, ranging between 90% (April 2017) to 100% (September, October, November 2016)

March to May 2017 saw performance fall slightly below the England average, however as of June 2017 for antenatal care the trust’s performance was back in line with the England average of 96%.

Friends and family test performance, percentage recommended (birth)

Between July 2016/17 the trust’s Maternity Friends and Family Test (birth) performance (% recommended) was generally in line with the England average, ranging between 90% (April 2017) to 99% (February 2017)

March and April 2017 saw performance drop slightly below the England average but as of June 2017 the trust’s performance for birth was back in line with the England average of 97%.

Friends and family test performance, percentage recommended (postnatal ward)

Between July 2016/17 the trust’s Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse than the England average, ranging from 85% (December 2016) to 97% (June 2016).
Only four of the 12 months in the period were either in line with or above the England average, but as of June 2017 the trust saw performance improve for postnatal ward to 97% above the England average of 95%.

**Friends and family test performance, percentage recommended (postnatal community)**

Between July 2016/17 the trust’s Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally worse than the England average.

All months in the period were below the England average, ranging from 83% (December 2016) to 95% (May 2017). As of June 2017 the trust’s performance for postnatal community was 93% compared to the England average of 98%.

(Source: NHS England Friends and Family Test)

**CQC Survey of women’s experiences of Maternity services 2015**

The trust performed about the same as other trusts for all 16 of the questions in the CQC Maternity survey 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.42</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.22</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.41</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>8.88</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>8.86</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.13</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.95</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.41</td>
</tr>
<tr>
<td></td>
<td>About the same</td>
<td>8.22</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>9.04</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.39</td>
<td></td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>6.97</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>6.86</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>8.10</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>7.73</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>About the same</td>
<td>5.77</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women's Experiences of Maternity Services 2015)

Curtains were in place behind the doors of every room in the labour ward and we saw these were closed when patient care was being delivered.

Skin to skin contact had been achieved in 100% of births on the labour ward in September 2017.

**Emotional support**

Staff provided emotional support to patients to minimise their distress, including counselling at the screening stage. There was a bereavement midwife who provided specialist support to those who had lost their baby. Counselling was available at the screening stage if anomalies were found on the scan.

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

Staff involved patients and those close to them in decisions about their care and treatment. There were open visiting times and partners and families were welcomed onto the wards.

When advice was given over the telephone in the triage area staff gave reassurance to women, explained the plan of care clearly and checked their understanding.

Partners told us they had felt included, involved and supported by staff on the wards.

Women had been able to choose their place of birth and this was supported unless clinical changes meant it was not possible.

There were open visiting times to enable partners to visit at a time that suited them and stay with women if they wished them to.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. This included the provision of translation services and specialist midwives.

Bed Occupancy

Between 1/1/2016 and 30/06/2017 the bed occupancy levels for Maternity were generally lower than the England average, with the trust having 57% occupancy in Quarter1 2017/18 compared to the England average of 58.9%

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Women could refer themselves into the service as well as being referred via the GP. We saw staff encouraged women to self-refer.

There were three midwives in the young person’s team who supported women under the age of 18 and those between 18 and 19 with additional social needs such as homelessness. These midwives supported the women throughout their care and had an attendance rate of 94% to 96% at appointments.

Community midwives had their bases at local children’s centres which meant women could easily access them.
Meeting people’s individual needs

The service took account of women’s’ individual needs.

Women who were waiting for elective caesarean sections were now accommodated on the antenatal ward. They had previously been on the postnatal ward; however it was felt the antenatal ward gave them a better patient experience.

Translators were available for either face to face or telephone translation. We saw these were used in various areas of the maternity service. Where possible staff who spoke the same language as the ladies would be allocated to their care.

Specialist midwives provided both support and direct care to women using the service. Two midwives offered support for women with complex needs and one provided counselling during the screening stages. The specialist midwives within the trust attended a number of antenatal clinics to provide additional support for asylum seekers, those women with drug and alcohol dependency and diabetes. They were also available to offer support and guidance to the other midwives.

There were four midwives in the trust who provided support to women aged 18 years and younger. They supported women through their pregnancy, accompanying them to clinic visits which had resulted in a good attendance rate. The specialist young people’s midwives were also trained in family planning and were able to administer contraception following birth.

Access and flow

People could access the service when they needed it. However there could be delays moving women between units at times of high activity.

We reviewed the documentation for a recent closure of the maternity unit to admissions. This was appropriate for the level of activity at the time to ensure safe care and treatment could continue. Staff reported requests for closures of the unit were reviewed by an appropriate senior staff member and closure did take place when patient safety issues were identified. This had improved since the last inspection.

Staff reported there could be delays in transferring patients from the triage and day assessment units to the antenatal wards. This was monitored during the rounding process and any patients at risk would be escalated to the manager on call. There were a low number of births on this unit with eight between October 2016 and September 2017. Investigations into each of these were completed and staff told us about lessons learnt where the birth at this location had been avoidable.

Theatre time for elective caesarean sections was allocated five days per week. This improved the ability to plan the surgical activity. The second obstetric theatre was available for emergencies and those women who progressed to caesarean sections from induction of labour.

The antenatal clinic waiting times had improved since August when there had been an increase in the number of registrars in the clinics.

There were plans to change the letters women received for their appointments for the antenatal clinic. Currently they received two separate appointment times if they required a scan and this meant the time of their appointments was confusing.

There was no system of informing patients of the waiting time in antenatal clinic, although midwives told us they let patients know this verbally.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
Summary of complaints

Between June 2016 and May 2017 there were 45 complaints about Maternity services (5.5% of all complaints).

The trust took an average of 65 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 11 complaints still open and yet to be completed.

There were 20 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 44%.

Royal Oldham Hospital: there were 22 complaints (48.8%)

There were five other complaints relating to maternity services in general.

(Source: Provider Information Request P55)

We were given examples of how learning from complaints had taken place. This included meeting with complainants to understand their experience, sharing information via email and at safety huddles.

Information about how to complain was available in all areas of the maternity services.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Since the last inspection there had been changes to the leadership of maternity services, including midwifery and medical leadership. Staff of all grades reported significant improvements through these changes.

We saw development opportunities had been provided, since the last inspection, for staff of various grades. This included supporting midwives to move to the next band, promotions to ward manager level and development of specialist roles.

The support provided to midwives out of hours and at times of high activity had been improved. Staff reported this was now formalised and consistent with managers providing additional support when it was necessary.

We observed good working relationships between midwifery and medical managers. They discussed how they were working together to change and improve practice and management systems.

Medical staff reported improvements in their leadership. This included better inclusion in meetings and decision making, being able to discuss issues and concerns openly and being listened to by senior medical managers.

Vision and Strategy

Senior medical staff and midwives told us there were plans to develop the antenatal pathway to include an increase in specialist antenatal clinics and multi-disciplinary working with other medical colleagues.

There were plans to work more closely with other trusts in the area to learn from their practice and provide a link for staff development.

Culture
Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff of all grades and in various roles told us the culture had changed and improved since the last inspection. They said they could now speak up freely if they had concerns and felt they would be listened to and their concerns acted upon. They were aware of who they could escalate issues to if they were not satisfied at the outset.

We saw a culture of openness and learning had developed which had changed from one of blame we were told about at our last inspection.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care was paramount.

There had been improvements to the governance of maternity services since the last inspection. There was a clear governance structure and process for monitoring performance. Managers were clear about their roles and responsibilities within the system which included attendance at weekly and monthly meetings, providing information for reports and escalating any concerns through a clear process.

Concerns about the care of deteriorating patients had been raised at the last inspection and through a coroner's report. This included the maternity early warning scores not always being completed accurately and patients not receiving a medical review in a timely way. A daily audit of the scores in the maternity services had been completed in the month of August. This showed improvements in all areas of the assessment. However we found the actions taken were not adequate to ensure the care of deteriorating patients was safely managed.

We were told the implementation of review of mortality had improved since the last inspection. This was now led by the governance lead, with more midwifery input and better junior doctor attendance. It was reported the lessons learnt and action plans were clearer and shared well with all staff.

Practice review meetings had been introduced twice weekly which were led by the on call consultant. These provided an opportunity to review the care of specific patients, identify good practice and any issues where further training or changes in practice were required.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Senior doctors told us attendance at the monthly perinatal mortality meetings was good and had improved since the last inspection. This was a multi-disciplinary meeting with paediatric doctors and midwives.

A senior midwife and nurse forum had been developed where issues and ideas were discussed and learning shared. Bi-monthly senior managers walked around a specific unit and shared their observations to aid improvement.

There was a meeting to discuss risks in maternity services on a weekly basis. This was compulsory for all unit managers. Incidents, complaints and learning from coroner’s cases were discussed. Root cause analysis reports were presented and changes in policy and practice agreed. Managers discussed how these meetings had improved joint working for improvement and communication about risks across maternity services.
Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were several mechanisms in place to ensure ongoing staff engagement took place. This included newsletters, emails, notices in staff areas and discussions at safety huddles. Staff told us this had improved since the last inspection.

Each ward or department had a monthly meeting. Although in some areas we were told attendance was not as high as the managers would like this was seen by staff as an opportunity to discuss any issues and keep abreast of changes. These meetings were open to staff of all grades.

We observed staff asking women and their partners for their feedback about their experiences while on the unit. This included completing friends and family and other feedback forms.

A patient engagement event had been held in maternity services during the inspection. This was to obtain the views of patients who had used or were using the service.

We were told of meetings and information sharing events with other stakeholders to make sure all those involved with the trust were abreast of any pertinent information and future planning.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The practice educator midwives had developed a learning programme which staff told us was an improvement on the previous system. They said there was a good variety of training available, delivered in various ways and they were supported and encouraged to complete it.

The training was multi-disciplinary with midwives and doctors. Both said this was good for building effective working relationships and greater understanding of roles and responsibilities.

The criteria for admission to the midwifery led birth unit was under review. This was to identify any additional patients who could use this facility to increase its usage and the number of births in that unit.

Two midwives in the midwifery led birth centre and some on community had completed a hypnobirthing course. They offered this to patients as an additional service.

There were plans to introduce acupuncture in the midwifery led birth centre and the use of other therapies such as aromatherapy were being explored.

In the antenatal clinic there were plans to assign midwives to work with specific obstetricians. It was thought this would improve joint working and help the efficiency of the clinics.

A system of practice reviews had been introduced. This meant themes and trends were identified through the review of cases and changes to policy resulted. Examples of this included changes to guidelines about use of fluids and identification of a rise in the use of general anaesthetics in caesarean sections.

Midwives had visited a neighbouring NHS acute trust’s maternity unit to observe their practices. As a result several changes had been made. These included the introduction of a patient board in the triage area to provide an overview of activity at any given time.
Services for children and young people

Facts and data about this service

The trust has 111 inpatient paediatric beds across two sites – North Manchester General Hospital and The Royal Oldham Hospital. The 104 inpatient beds include 56 Neonatal and 3 HDU beds.

In addition to the inpatient beds across two sites, the trust also provides paediatric outpatient services at Fairfield General Hospital, Rochdale Infirmary, The Royal Oldham Hospital and North Manchester General Hospital.

(Source: Routine Trust Provider Information Return (RPIR) – Beds tab)

The trust had 16,602 spells between June 2016 and May 2017.

Emergency spells accounted for 92% (15,232 spells), 4% (687 spells) were day case spells, and the remaining 4% (683 spells) were elective.


![Percentage of spells in children’s services by type of appointment and site]

Total number of children’s spells by site, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Oldham Hospital</td>
<td>8,339</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>8,214</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>49</td>
</tr>
<tr>
<td>This trust</td>
<td>16,602</td>
</tr>
<tr>
<td>England Total</td>
<td>1,100,894</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

The Royal Oldham Hospital children and young people services consist of a paediatric ward, a Paediatric Observation and Assessment Unit (O & A unit) and a Neonatal Intensive Care Unit (NICU).

The Department of Neonatology is based on the Neonatal Intensive Care Unit at the Royal Oldham Hospital. The unit is one of three tertiary referral centres for the Greater Manchester Network, which were developed following ‘Making it Better’; the reconfiguration of maternal, neonatal and paediatric services in Greater Manchester, which was completed in 2012.

The unit at the Royal Oldham Hospital developed from a local neonatal unit with two intensive care and two high dependency cots to a large neonatal intensive care unit with 37 cots: 18
intensive and high dependency cots and 19 special care cots.

The unit provides tertiary neonatal intensive care for babies born in the North West of England in addition to high dependency and special care services for the local community. The unit is a recognised cooling centre for infants with hypoxic ischaemic encephalopathy and also provides high frequency and inhaled nitric oxide. The Unit is recognised as a centre for Higher Specialist Training in Neonatology.

Most other services for children and young people under 16 are provided from the paediatric ward and in the observation and assessment unit. The ward consists of 20 inpatient beds, two of which are designated HDU beds. The beds are laid out in nine individual cubicles and four four-bedded bays. The ward space has additional beds so provision can increase to 25 beds, 11 cubicles and two HDU beds. At the time of our inspection the extra beds were closed.

The service is provided for children and young people 0-16 years. Referrals are received from Accident and Emergency, GPs, Community staff and Tertiary Centres for shared care. Referrals can be acute referrals for short stay assessment and observation, inpatient treatment, planned referrals for day case procedures/investigation or outpatient consultation.

The Children’s service also provides assessments for children referred by Social Services for child protection (Section 47) medicals. This service is provided by Consultant Paediatricians Monday to Friday, 9am to 5pm and in the acute ward environment out of hours.

The Paediatric Observation and Assessment Unit has a waiting room and a separate observation and assessment area with six trolleys. One of the assessment trolleys is in a side room within the assessment area. This unit is open from 9am til 12 midnight, 7 days per week.

The paediatric ward has a playroom, a treatment room, a dining room, a sensory room and a teenager’s room. This unit accepts referrals from GPs, A&E, Health Visitors and Community Nursing teams. Children aged 16 or over, unless a paediatrician knows them, are seen within the main hospital by adult services. At The Royal Oldham Hospital Children’s surgery is performed from the paediatric unit.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

Staff received mandatory training in systems, processes and practice. Training was done by e-learning or face to face sessions. An electronic system allowed staff and their managers to review training status. The system identified and notified staff when they needed to complete refresher training.

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services, such as maternity, as well as those working in children’s services)
Medical and dental staff in the Women’s and Children’s division met the 90% target for mandatory training compliance for three modules only. Basic life support training had the lowest compliance levels with only 60% of eligible medical and dental staff having been trained.

Nursing and midwifery staff in the Women’s and Children’s division met the 90% target for mandatory training compliance in five modules. Both waste management and infection prevention (non patients) achieved 100% compliance, however the requirement for eligible staff members for these modules was very low with only one and two members respectively eligible for training in these areas.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

During our inspection we reviewed mandatory training records for nursing staff on the children’s ward, which showed that 93% of combined core training had been completed and 83% of combined essential job related training had been completed.
Safeguarding

We found that overall children’s services staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

However, Safeguarding training completion rates did not meet trust targets for level 3

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division is shown below:

(N.B – the below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services)

Compliance was almost achieved with 89.5% compliance, which equated to 145 of the 162 eligible staff members completing the training.
Nursing and midwifery staff in the Women’s & Children’s division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

All trust staff receive face to face Safeguarding Level 1 training at induction and online level 2 training. During our inspection we reviewed safeguarding compliance for nursing staff, which indicated that 96% of staff had completed Safeguarding Children Level 2 training against a trust target of 90%.

It has been identified that all clinical staff who work with children should be trained to level 3 to be compliant to intercollegiate guidance. A proposal has been put to the board for approval to extend level 3 training to band 5 nurses.

The trust had introduced a new safeguarding team as part of the new integrated care model. There was a range of safeguarding policies and procedures in place and staff we spoke with indicated that they knew how to access these policies.

Staff told us that safeguarding incidents were made online and that the safeguarding team would usually make contact the following day. Safeguarding incidents were reviewed by a senior nurse and discussed at a fortnightly safeguarding meeting led by one of the consultants.

However, children with child protection concerns are at risk of not having their safeguarding needs met in a timely manner and referrals to children’s social care were not routinely quality assured by the safeguarding team due to capacity. This meant that not all referrals would be of high quality to ensure that children’s social care have the information they need to inform the action taken and service provided.

Reflective safeguarding practice was assured through one to one safeguarding supervision for midwives by the trust’s safeguarding team, which was also beginning to be offered to paediatric trained nurses on the paediatric wards. In addition, peer review group safeguarding sessions were facilitated on a quarterly basis for these staff groups. This enabled oversight of safeguarding cases and encouraged practitioners to reflect and improve their own work with children and young people.

Staff told us that if a baby had a social worker or had special circumstances, then the ward would always have a discharge planning meeting with the consultant, health visitor, social worker, children’s community nursing team, parents and safeguarding team.
We reviewed the records of two patients who were on the ward following self-harm. They had been immediately referred to the child and adolescent mental health team who attended the ward within the hour. Healthy young minds attended the ward and one assessment was ongoing whilst we were on the ward and this involved speaking to the patient and the mother about the available support from the team. We were able to see evidence that the correct pathway was followed for the children, which was to ensure the child was medically fit prior to referral to the mental health team; then a decision was made as to whether the child needed to go home with support or be admitted to a mental health ward.

Staff had a good understanding of the process and said that relationships with the Child and Adolescent Mental Health Services (CAMHS) teams were very good.

Staff told us that learning from safeguarding incidents was shared with staff, for example via a newsletter.

The services had a pathway in place for Child Sexual Exploitation (CSE) and victims of Female Genital Mutilation (FGM). Arrangements were also in place to collect data for the use of safeguarding boards and local authorities.

All staff had access to Royal College of Nursing paediatric guidelines 2016-2018 through the intranet. The guidelines highlight different types of safeguarding concern and direct staff to actions to be taken in the event of harm or abuse of children. The guidelines also described the correct discharge process in children’s services where safeguarding risk is present.

The Royal Oldham Hospital children’s service is part of Pennine Acute Trust. The trust produces an annual safeguarding report which was last produced in April 2017. The report noted that work had been done with staff to increase awareness of multi-agency work and child protection links. The report described a marked increase in staff referring to social care because of the work undertaken on child protection concerns by the safeguarding team.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Whilst in general staff followed Trust protocols to manage infection risk, the governance to monitor infection risk was not always robust.

**CQC Children’s Survey 2014 – Q26**

In the CQC children’s survey 2014 the trust scored 8.84 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

We found children’s services used the trust wide infection prevention and control policy. Staff were provided with training in infection prevention and control.

The children’s ward and neonatal unit were visibly clean and all wards had hand gel available outside the ward and inside the ward. We observed staff using the hand gel dispensers.

We saw evidence that staff were encouraged and supported to adopt safe cleaning, infection control and hygiene practices when on duty. Protocols were in place to help staff remember the important aspects of good practice, for example, cleaning procedures with prompts were displayed on walls to remind staff about hygiene practice.

Hand hygiene for staff was monitored in wards and departments with results of audits displayed in public areas; these showed 100% compliance. However, infection prevention and control was not featured on the Paediatric Dashboard and the ‘infection control hygiene results Checklists Observations August 2017’ audit indicated a compliance of 89% in the children’s unit and 100% compliance in the neonatal unit at The Royal Oldham Hospital. Furthermore, the Children’s Unit...
Newsletter (Matron’s Message) for September indicated 98% compliance with hand hygiene, whilst the October Newsletter indicated 85% compliance across the Fairfield, Oldham and Rochdale hospital sites.

We reviewed two sets of Neonatal Directorate Quality and Performance Meeting minutes (August 2017 and October 2017) and we noted that a number of items with regards to ‘infection / healthcare associated infections’ on minutes of the meeting in August 2017 had not been changed or changed significantly when documented on the minutes of the meeting in October 2017. Also, it was not evident if progress had been made against these items.

Supplies of disposable items, such as gloves, waste bags and wipes, alongside commodes, were kept in the dirty utility area on the children’s ward; this space was cramped and commode cleaning checks had not been recorded on 13 out of 33 records during October 2017.

Cots were cleaned in the utility room and had ‘I am clean’ stickers added. We observed these cots to be free from visible dirt and soil.

All syringe drivers had ‘I am clean’ stickers on, but we observed that intravenous stands did not have ‘I am clean’ stickers with dates on. However, we observed the intravenous stands to be free from visible dirt and soil.

Internal arrangements were in place for managing waste and handling clinical specimens. Sharps bins were dated, signed and partly closed.

Cleaning schedules were in place in all of the areas we inspected, which cleaning staff were required to follow. These were displayed for patients and explained the areas to be to be cleaned and frequency of cleaning.

The outdoor play area near the children’s ward was littered and appeared dirty. We observed that play equipment was in need of some updating.

We were told that cleanliness was discussed each month at clinical governance meetings to ensure there was senior oversight of hand hygiene and cleanliness for each area of children’s services. However, we did not review minutes of these meetings.

Environment and equipment

We found that overall children’s services had suitable premises but equipment was not always looked after well. Checking of equipment within time frames was sometimes not maintained and fridge temperatures not checked.

CQC Children’s Survey 2014 – Q2, Q7, Q25

In the CQC children’s survey 2014 the question ‘Did you feel safe on the hospital ward?’ was not applicable to the trust.

The trust scored 8.89 out of ten for the question ‘Did you feel that your child was safe on the hospital ward?’ This was about the same as other trusts.

The trust scored 8.57 out of ten for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’ This was about the same as other trusts.

A list of all scores from the survey which fall under the safe domain is listed below.

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Did the ward where your child stayed have appropriate equipment or adaptions for your child?</td>
<td>S3</td>
<td>0-15 Adult</td>
<td>8.57</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26. How clean do you think the hospital</td>
<td>S3</td>
<td>0-15 Adult</td>
<td>8.84</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
room or ward was that your child was in?

<table>
<thead>
<tr>
<th>Question</th>
<th>Adults</th>
<th>CYP</th>
</tr>
</thead>
<tbody>
<tr>
<td>53. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>S3</td>
<td>S3</td>
</tr>
<tr>
<td>7. Did you feel that your child was safe on the hospital ward?</td>
<td>S3</td>
<td>S3</td>
</tr>
<tr>
<td>2. Did you feel safe on the hospital ward?</td>
<td>S3</td>
<td>S3</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Access to ward areas on the children’s and neonatal unit was controlled by security doors with intercom. We observed reception and ward staff following guidance for monitoring access to wards and units appropriately.

Emergency equipment for resuscitation was located on resuscitation trolleys in accessible positions on the children’s ward, neonatal ward and in the outpatient areas. Resuscitation trolleys were secured with security tags. A pictorial guide for checking the items of equipment to be found in each drawer was available for staff to follow, together with an aide memoire for undertaking Advanced Paediatric Life Support.

The local resuscitation policy was out of date at the time of inspection. We saw that records of daily checks were not completed for four dates in September 2017, however, we observed weekly checks had been completed fully for this period.

The oxygen cylinder on the resuscitation trolley was in date and safely secured to the trolley.

Ward areas were light and airy, with child friendly wall decorations, and the children’s ward had an indoor and outdoor play area. A ward bay on the children’s ward had been adapted to provide a children’s dining area, which was bright and clean and equipped with a range of suitable children’s tables, chairs and highchairs.

The children’s unit had a parents’ room, with access to hot drinks, toiletries and meals and drinks available to breastfeeding mothers.

The admissions and discharge lounge was well equipped and had ample information leaflets available for parents and carers.

Staff had access to the equipment they needed to care for patients and maintained and used it in a way that helped keep people safe. Standard operating procedures were in place to help staff check equipment. Staff told us these operating procedures were readily available on the intranet.

Records showed that equipment servicing for items, such as blood pressure monitors, electrocardiogram (ECG) machines and neonatal ventilators, were completed by medical engineering staff. All the equipment we checked was within servicing date. However, we found five syringe drivers in use which indicated ‘requires service’ when switched on. When we raised this with the staff, they removed these syringe drivers and sent them for servicing.

 Fridges for storing medicines at low temperatures were used on the children’s ward and the neonatal unit. We saw that fridge temperature checks were all recorded as in range, except for nine dates missing in September 2017 and in October 2017, when for five days the temperature was not recorded as being in range on the children’s ward. On the neonatal unit, for one day in September 2017 and for six days in October 2017 fridge temperature checks had not been recorded.

 On the neonatal unit we found a fridge used for storing breast milk, which was not working. This had been reported by staff and alternative provision was in place to store the milk safely.

 On the children’s unit, there were two dirty utility rooms, one equipment room, one linen room and a kitchen, which were all secured with key pads. We found that the dirty utility room in the children’s unit was cramped.

 We saw that an equipment storage area on the neonatal unit was congested with large
equipment; however, this area appeared safe and was being managed appropriately. Staff informed us that it could be difficult at times to find space for storing certain types of equipment.

All fire extinguishers had been checked and were in date.

Assessing and responding to patient risk

Medical review information was provided via the use of Paediatric Bedside guidelines which staff accessed on the internal intranet.

We found that children’s services had suitable ways of assessing and responding to patient concern through its bedside guidelines.

The level of the seniority of reviewer for patients was dependent on the risk the child presented and the state of deterioration. The higher the risk, the higher the escalation process.

The service used the Manchester Children’s Early Warning Score (MANCHEWS). MANCHEWS is a tool to identify early warning signs of deterioration in a patient’s health. The tool uses a traffic light scoring system, alerting the staff to the clinical condition of the patient and the requirement for review.

An audit carried out by the trust in early 2017, looked at compliance with completing the MANCHEWS scoring tool. For the children’s unit at The Royal Oldham Hospital, 25 out of 25 MANCHEWS tools had all patient observations completed, however, 8% of the MANCHEWS scores had not been graded correctly.

The trusts used the Manchester Children’s Early Warning Score (MANCHEWS), which is a tool to record early warning signs of deterioration in a paediatric patient’s health; the tool assists nursing staff to make an informed assessment of when to escalate a paediatric for a medical review.

The audit identified that only 14% of patients with a red or amber Early Warning Score had a label placed in their medical records, only 28% of patients with a red or amber Early Warning Score were escalated appropriately and in only 33% of the Early Warning Scores reviewed a consultant paediatrician was informed of all patients with a red Early Warning Score.

However, during our inspection we reviewed eight patient records and observed that Early Warning Scores were completed correctly and that nurses escalated paediatric patients appropriately for review by medical staff.

Nursing staffing

We found that the service had considerable staff shortages for nursing staff and did not use an acuity tool to determine the required levels of nursing staff to manage patient dependencies, however, we saw there had been no noticeable impacts on patient safety and quality of care as a result of low staffing levels.

All staff we spoke with within the paediatric ward and the neonatal unit indicated that nurse staffing levels were low and shifts were often understaffed against planned rotas. We observed indeed that nursing levels did not always meet the planned standards.

Staff from the neonatal unit often covered the paediatric ward, but did not always feel they were competent to do so; in order to mitigate for this, they used a check list.

At time of the inspection, the service was not using a formal acuity tool. Staff told us that caseload should be one nurse to two patients on the High Dependency Unit and one nurse to five patients on the ward, however, often the ratio was one nurse to seven or eight patients on the ward.

Staff told us that new starters would have a four week supernumerary period.
As nurse staffing levels were low, the children and young people services frequently made use of agency staff. Also, on a regular basis staff from the North Manchester General Hospital children and young people services would come over to assist.

However, although low nurse staffing levels did have an impact on staff morale, we found there was no noticeable adverse impact on patient safety or quality of care. Between June 2017 and October 2017, 10 incidents specifically related to staffing related issues (for example: staffing levels, skill mix and performance) had been reported, but all incidents were graded as no harm.

The staff felt that this impacted on elements of care, such as patient education and delayed discharges on occasion. However, the role of the diabetic nurse was provided by a neighbouring trust and the trust was exploring a solution to improve diabetic care provision for patients.

Between December 2016 and May 2017, there were fewer nurses in post across children and young people services than planned, with an average shortfall of 20 whole time equivalent nurses. However, the trust had plans in place to increase nurse staffing levels.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in children’s services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Services for Children &amp; Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE in post</td>
</tr>
<tr>
<td>December 16</td>
<td>209.85</td>
</tr>
<tr>
<td>January 17</td>
<td>210.81</td>
</tr>
<tr>
<td>February 17</td>
<td>212.81</td>
</tr>
<tr>
<td>March 17</td>
<td>214.98</td>
</tr>
<tr>
<td>April 17</td>
<td>211.54</td>
</tr>
<tr>
<td>May 17</td>
<td>213.50</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates
Between June 2016 and May 2017 the trust reported an average vacancy rate of 8.8% for nursing and midwifery staff in children’s services;

- Royal Oldham Hospital: 9.4%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
Between June 2016 and May 2017, the trust reported an average turnover rate of 1.1% for nursing and midwifery staff in children’s services;

- Royal Oldham Hospital: 1.3%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Between June 2016 and May 2017 the trust reported an average sickness rate of 6.7% for nursing and midwifery staff in children’s services, which is above the overall trust target of 4.6% for sickness rates.

- Royal Oldham Hospital: 6.3%
Medical staffing

The service did not have sufficient staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was a shortage of medical staff across different grades.

The trust has reported the following planned and actual staffing figures for medical staff working in children’s services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>54.40</td>
<td>55.50</td>
</tr>
<tr>
<td>January 17</td>
<td>53.40</td>
<td>55.50</td>
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<tr>
<td>February 17</td>
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<tr>
<td>March 17</td>
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<td>55.50</td>
</tr>
<tr>
<td>April 17</td>
<td>53.80</td>
<td>55.50</td>
</tr>
<tr>
<td>May 17</td>
<td>53.80</td>
<td>55.50</td>
</tr>
</tbody>
</table>

Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 2.4% for medical staff in children’s services.

- Royal Oldham Hospital: 3.1% vacancy

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 2.6% for medical staff in children’s services;

- Royal Oldham Hospital: 3.5%

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 0.6% for medical staff in children’s services which is better than the overall trust target of 4.6% for
sickness rates.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average whilst the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 89 whole time equivalent staff working in Children’s services at The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Major incident awareness and training

The service planned for emergencies and staff understood their roles if one should happen.

The children and young people service had recently received a small number of casualties following a major incident and dealt well with this. The trust has a Major Incident Plan in place and in the event of a major incident, the lead would be taken from the director on call.

Other CQC Survey Data
CQC Children’s Survey Data – Q53

In the CQC children’s survey 2014 the trust scored 9.77 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’

The measure is if children spent most of their time of a children’s ward rather than an adult ward. This was about the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

Records

We found that staff did not always keep appropriate records of patients’ care and treatment. We observed that some nursing charts had not always been completed appropriately.

We observed that Visual Infusion Phlebitis (VIP) charts were not always completed.

The Pennine Acute Hospitals NHS Trust Paediatric Annual Record Keeping Audit 2016 indicated that compliance against 13 standards of good record keeping (as outlined in the Clinical Record Keeping Policy) and two additional standards, was poor. However, at the time of our inspection, we noted that records were comprehensively completed; we reviewed 11 sets of records (seven on the neonatal unit and four on the paediatric ward), all of which were completed appropriately.
**Medicines**

We found that the service did not always prescribe, give or record medicines well with recording medicines errors as a result.

The service did not always prescribe, give or record medicines well; in the six month period between June 2017 and October 2017, there were 14 incidents recorded related to medicine errors. Thirteen of these incidents resulted in no harm, whilst one incident resulted in low harm.

We noted from the ‘Neonates Improvement Plan TROH V3’ (23 October 2017) that there is a milestone/task to improve the management of clinical incidents, to support development of a culture in which lessons are learned; in the comment section it refers to medication errors to be discussed at the Safe Administration Medications meetings.

Staff used a medicine management policy when managing medicines and controlled drugs in line with legislation.

Medicines were checked regularly by nurses. Pharmacy staff checked contents, expiry dates and stock levels weekly.

In all the areas we inspected, medicines, including controlled drugs, were stored securely in an organised way and we observed that medicines were all within expiry dates.

Controlled drugs were stored in a separate cupboard on the High Dependency bay on the children’s ward. We noted that patients’ own controlled drug supplies were recorded in a separate log book, with medicines and doses administered correctly and accounted for.

**Incidents**

We found that the service did not manage patient safety incidents well. New incident reporting systems had recently been introduced at the time of inspection and processes to manage and share learning were not embedded.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for children’s services.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident type was:

- 1 HCAI/infection control incident meeting SI criteria
- 1 treatment delay meeting SI criteria
- 1 medication incident meeting SI criteria

*(Source: Strategic Executive Information System (STEIS))**
The Trust has an incident reporting system. Staff we talked with said they knew how to report an incident on the system and said they had received training. However, during the inspection no data on incident reporting training was available to us.

The trust had policies and procedures for reporting incidents or concerns; these policies and procedures were available to staff via the provider’s intranet. Staff we spoke with told us that they knew how to access the policies.

We reviewed three comprehensive incident investigation reports, which all detailed sections on learning and recommendations. There was a section that detailed arrangements for sharing learning, which was completed for two out of the three comprehensive incident investigation reports. We noted that learning from serious incidents was documented in the Children’s Unit Newsletter (Matron’s message), however, we were unable to ascertain how comprehensive the sharing of learning had been and if learning had led to improvements in practice.

Only two of the comprehensive incident investigation reports had actions plans; one action plan had no ‘by when’ time scales documented, whilst the second action plan had a few actions with no ‘by when’ time scales recorded. One action plan had no ‘progress update/s’ recorded, whilst on the second action plan the ‘progress update/s’ section had only been partially completed.

The children and young people services had a good incident reporting culture: between June 2017 and October 2017, 254 incidents had been reported within children and young people services across the trust.

Out of 254 incidents reported, 125 incidents were reported by the children’s unit, neonatal unit and Paediatric Observation and Assessment Unit (O & A unit) at The Royal Oldham Hospital; this constitutes to approximately 49% of all reported incidents over the six month period.

Of these 125 incidents recorded, 124 were confirmed as no or low harm and one incident was recorded and confirmed as moderate harm.

The incident where a paediatric patient sustained moderate harm was because of delays in treatment due to miscommunication during handover between medical staff. Although we did not see documented evidence of learning from this particular incident, during the inspection we observed handovers between shifts (by both nursing and medical staff) to be good and comprehensive and staff used the ‘Situation, Background, Assessment, Recommendation’ (SBAR) tool to facilitate prompt and appropriate communication.

Of the 125 incidents reported in the children’s unit and Paediatric Observation and Assessment Unit, 14 incidents related to medicine errors, 12 incidents related to treatment issues or delays (including delays in assessment or prescriptions), 10 incidents related to discharge (mainly self-discharge against medical advice), 10 incidents related to staffing related issues (for example: staffing levels, skill mix and performance) and 10 incidents related to equipment.

Staff we spoke with told us they received verbal feedback about incidents (at weekly unit meetings) and via the Children’s Unit Newsletter (Matron’s Message), however, although top clinical incidents were briefly described within the newsletter, there was no mention of individual incidents or documented learning arising from it. We viewed minutes from an Oldham Paediatric A&E Staff Meeting (June 2017) and noted that lessons learned were discussed following a serious incident and that incidents and subsequent actions had been discussed also.

We observed that incidents and concerns were discussed during staff huddles and we saw evidence that incidents were discussed at meetings (for example Neonatal Directorate Quality and Performance meetings). However, we could not ascertain from minutes of meetings if shared learning had resulted in improved practices.

The children and young people services had 2WTE practice educators shared between all four hospital sites (Fairfield General Hospital, The Royal Oldham Hospital, Rochdale Infirmary and North Manchester General Hospital), who implemented training following investigations of serious incidents. For example, following a sepsis incident, the practice educator introduced a sepsis
module for three different age ranges.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or catheter urinary tract infections between July 2016/17 for children’s services.

(Source: NHS Digital)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness.

A range of clinical guidelines were available to staff via the trust’s intranet, however, during the Neonatal Directorate Quality and Performance Meeting in October 2017, it was identified that 11 of the guidelines had expired and that three guidelines were about to expire. As the minutes of the meeting did not detail actions, it was not clear who was going to review and update the guidelines and by when.

**Audits**

The children and young people service carried out audits, such as: Early Warning Score audit, documentation (records) audit and pain management audit. A number of the audit results we saw were not recent.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

**Pain relief**

Pain scores were recorded and analgesia administered as needed.

**Patient outcomes**

We found the service monitored the effectiveness of care and treatment and compared local results with those of other services.

The service had put a number of audits in place to measure compliance to national guidelines and show learning from audit results.

Data we received showed that patient outcomes were generally at the England average, however, in some cases patient outcomes were lower than the England average.
Emergency readmission rates within two days of discharge

The tables below show the percentage of patients (by age group) who were readmitted following an elective admission. The tables show only those specialties where six or more readmissions recorded are shown in the table.

Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment specialty (February 2016 to January 2017)

There were emergency readmissions after elective admission at The Pennine Acute Trust among patients in the under 1 age group between February 2016 and January 2017. However no treatment specialty reported six or more readmissions.

Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment speciality (February 2016 to January 2017)

There were emergency readmissions after elective admission at The Pennine Acute Hospitals NHS Trust among patients in the 1 to 17 age group between February 2016 to January 2017. However no treatment specialty reported six or more readmissions.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that between February 2016 and January 2017 there was a similar percentage to the England average of under ones readmitted following an emergency admission in paediatrics.

A similar percentage to the England average of patients aged 1-17 years old were readmitted following an emergency admission in paediatrics, but there was a slightly higher percentage of 1-17 year olds readmitted following an emergency admission in general surgery when compared to the England average.

| Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2016 to January 2017) |
|---|---|---|
| Specialty | The Pennine Acute Hospitals NHS Trust | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| Paediatrics | 3.7% | 5,875 | 220 | 3.3% |

No other specialty at the trust had six or more readmissions

Source: Hospital Episode Statistics

Notes: This table shows the three treatment specialities at the trust with the highest volumes of readmissions, only those specialties where The Pennine Acute Hospitals NHS Trust had 6 or more readmissions recorded are shown in the table.

| Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment speciality (February 2016 to January 2017) |
|---|---|---|
| Specialty | The Pennine Acute Hospitals NHS Trust | England |
| | Readmission rate | Discharges (n) | Readmissions (n) | Readmission rate |
| Paediatrics | 2.3% | 8,965 | 208 | 2.7% |
| General Surgery | 4.2% | 433 | 18 | 3.3% |

No other specialty at the trust had six or more readmissions

Source: Hospital Episode Statistics

Notes: This table shows the three treatment specialities at the trust with the highest volumes of readmissions, only those specialties where The Pennine Acute Hospitals NHS Trust had 6 or more readmissions recorded are shown in the table.
Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

Between March 2016 and February 2017 the trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and diabetes, but was in line with the England average for the percentage of patients aged 1-17 years who had multiple readmissions for epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>The Pennine Acute Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1-17</td>
<td>17.3%</td>
<td>504</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>22.7%</td>
<td>75</td>
</tr>
<tr>
<td><strong>Epilepsy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>7</td>
</tr>
<tr>
<td>1-17</td>
<td>27.2%</td>
<td>81</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’. 

National Neonatal Audit Programme

In the 2016 National Neonatal Audit the trust’s performance was as follows:

Royal Oldham Hospital:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 89 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window.

This was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 485 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 85% of the eligible episodes.
This was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

**Are rates of normal survival at two years comparable in similar babies from similar neonatal units?**

There were 39 babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to this hospital for two year health assessment based on their final neonatal discharge.

Data was entered for 85% of the babies assigned to your unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014.

**What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?**

Definition of Bronchopulmonary Dysplasia:

A: Mild: respiratory support (Ventilation ,CPAP, BiPAP, HHFNC and or any oxygen) on day 28 + air at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

B: Significant: respiratory support on day 28 + respiratory support at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

There were 250 babies born < 32 weeks in this hospital who were included in the analysis for Bronchopulmonary Dysplasia.

Of these babies 99 were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Competent staff**

**Appraisal rates**

Royal Oldham Hospitals children’s services did not meet the trust targets for staff appraisals.

Between June 2016 and May 2017, 83% of staff working within services for children and young people (87% for staff in paediatrics and 79% for staff in neonates) within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 90%.

The 83% appraisal rate applies to nursing and midwifery registered, administrative and clerical and additional clinical services staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Royal Oldham Hospital 80% had received an appraisal.

(Source: Trust Provider Information Request P46)

We spoke with nine band 5 nurses from the neonatal unit at a focus group meeting, who confirmed that they had receive induction and additional training; for example, staff have a monthly ‘Safe Administration of Medicines’ (SAMS) day, they have access to bereavement training and some staff have completed Newborn Life Support (NLS) training.

When we reviewed the Workplace Induction compliance in the ‘Paediatrics Ward (North) Compliance Summary’ extract, four out of five staff had received a workplace induction (80%, against the trust’s target of 90%); it is likely that this compliance figure referred to new starters.
Staff in the neonatal unit told us that they also work towards a range of other clinical competencies, such as giving breast feeding advice, inserting and managing nasogastric tubes and operating neonatal equipment.

The Paediatrics Ward (North) Compliance Summary extract detailed that 36 out of 50 staff had had an appraisal (72%) against the trust’s target of 90%.

One hundred per cent of staff had completed Advanced Paediatric Life Support training.

We observed a ward round led by a senior doctor (ST7), which was well-organised and well-conducted.

**Multidisciplinary working**

We found that staff of different kinds worked together as a team to benefit patients in children’s services. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Patients under the care of children and young people services have access to a variety of healthcare professionals, such as consultants, junior doctors, (specialist) nurses, advanced practitioners, healthcare staff, physiotherapists, (specialist) dietitians, speech and language therapists, occupational therapists and play therapists. We did not observe multidisciplinary ward rounds or multidisciplinary team work per se.

**CQC Children’s survey 2014 – Q36**

In the CQC children’s survey 2014 the trust scored 8.14 out of ten for the question ‘Did the members of staff caring for your child work well together?’

This was about the same as other trusts.

*(Source: CQC Children’s Survey, RCPCH)*

**Seven-day services**

The hospital was reviewing its seven day service delivery programme. The Secretary of State for Health requested National Health Service England to develop & deliver services for 10 standards. The trust is concentrating on delivering 4 of these standards in the short term. The trusts targets include:

- A consultant review within 14 hours of admission
- Diagnostics & results should be available within 1 hour for critically ill patients, 12 hours for urgent patients & 24 hours for non-urgent patients
- There needs to be 24/7 access to key consultant led interventions, or pathways in place for them
- All patients in acute units should be reviewed twice daily unless documented otherwise

The hospital stated it has found it difficult to meet these standards due to a number of factors including; cost of the programme, staffing vacancies as well as restructuring of its service into care organisations.

Assessments for children referred by Social Services for child protection (Section 47) medicals was provided by Consultant Paediatricians Monday to Friday, 9am to 5pm and in the acute ward environment out of hours.

The Paediatric Observation and Assessment Unit was open from 9am till 12 midnight, 7 days per week.

The neonatal unit and children’s ward were open 24 hours a day, seven days a week.
Access to information

Staff did not always have access to up-to-date, accurate and comprehensive information on patients’ care and treatment, as IT systems were often very slow; this often delayed timely reviews or treatment interventions. However, all staff had access to an electronic records system that they could all update.

CQC Children’s survey 2014 – Q28

In the CQC children’s survey 2014 the trust scored 8.66 out of ten for the question ‘Did a member of staff agree a plan for your child’s care with you?’

This was About the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Other CQC Survey Data

CQC Children’s Survey Data

The trust performed about the same as other trusts in all of the questions relating to effective in the CQC children’s survey 2014

CQC Children’s Survey questions, effective domain, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Did a member of staff agree a plan for your child’s care with you?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.66</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you think the hospital staff did everything they could to help ease your child’s pain?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>7.97</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>E3</td>
<td>0-15 adults</td>
<td>7.78</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>36. Did the members of staff caring for your child work well together?</td>
<td>E4</td>
<td>0-15 adults</td>
<td>8.14</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>E5</td>
<td>0-15 adults</td>
<td>7.51</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24. Did your child like the hospital food provided?</td>
<td>E1</td>
<td>0-7 adults</td>
<td>6.17</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>11. Do you think the hospital staff did everything they could to help your pain?</td>
<td>E1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>4. Did you like the hospital food?</td>
<td>E1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Key:
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)
Is the service caring?

Compassionate care

Staff provided good care to patients with compassion and also provided emotional support.

CQC Children’s survey 2014

The trust performed worse than other trusts for four out of 14 questions relating to compassionate care in the CQC children’s survey 2014.

The trust scored worse for the following questions:

Q35 - Were members of staff available when you or your child needed attention?
Q10 - Did staff play with your child at all while they were in hospital?
Q40 - Do you feel that the people looking after your child listened to you?
Q41 - Do you feel that the people looking after your child were friendly?

CQC Children’s Survey questions, compassionate care, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Overall… (please circle a number)</td>
<td>C1</td>
<td>0-15 adults</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>35. Were members of staff available when you or your child needed attention?</td>
<td>C1</td>
<td>0-15 adults</td>
<td>7.46</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>8. Was your child given enough privacy when receiving care and treatment?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Did you think there were appropriate things for your child to play with on the ward?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>7.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>10. Did staff play with your child at all while they were in hospital?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>5.40</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>11. Did new members of staff treating your child introduce themselves?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40. Do you feel that the people looking after your child listened to you?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>7.70</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>41. Do you feel that the people looking after your child were friendly?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.33</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>42. Do you feel that your child was well looked after by the hospital staff?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.43</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Were you treated with dignity and respect by the people looking after your child?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.72</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Were you given enough privacy when you were receiving care and treatment?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>18. Do you feel that the people looking after you listened to you?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>19. Do you feel that the people looking after you were friendly?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>20. Overall… (please circle a number)</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Key:
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

During our inspection we observed that nursing staff treated children with kindness and reassurance when they were being looked after on the children’s ward, outpatient department and neonatal unit.

On the neonatal unit, lighting was dimmed in one of the bays and staff were as quiet as possible;
this helped babies to be more settled and allowed parents to spend time quietly with their babies. Parents said staff respected their privacy and dignity. When staff and doctors came to speak with children and those close to them in cubicles, curtains were drawn to provide privacy.

We viewed four comments cards, with positive feedback about staff, such as: “they have been there every step of the way keeping so calm and fighting our course. We appreciate all your patience and genuine love and care…”, “Thank you for all your kindness during our stay” and “Thank you for being such a friendly, supportive team”.

Staff told us that play staff normalised the environment. On inspection we saw a number children laughing and playing with play specialists.

Understanding and involvement of patients and those close to them

CQC Children’s survey 2014

The trust performed about the same as other trusts for 17 out of 19 questions relating to understanding and involvement of patients and those close to them in the CQC children’s survey 2014.

The trust performed better than other trusts for the following question:

Q43 - Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?

The trust performed worse than other trusts for the following question:

Q19 - Were you told different things by different people, which left you feeling confused?

CQC Children’s Survey questions, understanding and involvement of patients, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Did hospital staff tell you what was going to happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.10</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>27. Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.60</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29. Did you have confidence and trust in the members of staff treating your child?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.22</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>30. Were you encouraged to be involved in decisions about your child’s care and treatment?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.91</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.90</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32. Did staff ask if you had any questions about your child’s care?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.49</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38. Did a member of staff tell you what would happen next after your child left hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.74</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.71</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>44. Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.61</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
45. After the operation or procedure, did someone explain to you how the operation or procedure had gone in a way you could understand?  
C2 0-15 adults 9.07 About the same as other trusts

47. Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?  
C2 0-15 adults 9.60 About the same as other trusts

48. Did a member of staff give you advice about caring for your child after you went home?  
C2 0-15 adults 7.80 About the same as other trusts

50. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?  
C2 0-15 adults 7.27 About the same as other trusts

13. Did members of staff treating your child communicate with them in a way that your child could understand?  
C2 0-7 adults 7.65 About the same as other trusts

19. Were you told different things by different people, which left you feeling confused?  
C2 0-7 adults 7.10 Worse than other trusts

1. When you first arrived at hospital, did people working at the hospital tell you what was going to happen to you while you were there?  
C2 8-15 CYP NA NA

5. Did hospital staff talk to you about how they were going to care for you in a way that you could understand?  
C2 8-15 CYP NA NA

13. Before the operation or procedure, did someone tell you what would be done?  
C2 8-15 CYP NA NA

14. Afterwards, did someone from the hospital explain to you how the operation or procedure had gone in a way you could understand

Key:
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Data available from parents/carers of 0 – 7 year olds only)
(Data available from 8 – 15 year olds and young people)
(Data available from parents/carers of 0 – 15 year olds only)

(Source: CQC Children’s Survey, RCPCH)

We found the trust did support parents and patients to be involved in care. Patients described how staff showed them respect and ensured their dignity was maintained.

We found staff demonstrated a good understanding of the needs of children’s and their carers.

Feedback from parents on the neonatal unit was collected using a form in the shape of a baby vest, with smiley faces for parents to indicate their experiences. However, we did not see the results of this feedback.

We spoke with the parents of one patient on the High Dependency Unit who had complex cardiac needs and the parents felt that staff were not always prepared to look after their child, although they acknowledged that staff did their best with the resources they got. They said that staff would contact a tertiary centre for advice when needed. The parents were not able to sleep in the High Dependency Unit, as there was not sufficient space to accommodate this.

Parents of patients in the neonatal unit did get free parking and discount in the canteen.

**Emotional support**

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for the questions relating to emotional support in the CQC children’s survey 2014.
CQC Children's Survey questions, emotional support, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did a member of staff tell you what to do or who to talk to if you were worried about your child when you got home?</td>
<td>C3</td>
<td>0-7 Adults</td>
<td>8.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>7. If you had any worries, did someone at the hospital talk with you about them?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>15. Did hospital staff tell you what to do or who to talk to if you were worried about anything when you got home?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Key:
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

Staff provided emotional support to patients to minimise their distress. We found a high level of emotional support provided by staff in children’s services. Staff and were able to put themselves into the position of others and therefore offer meaningful support.

We saw that staff in all areas understood the emotional impact for children and parents of their child being ill and in hospital. Staff spoke in a caring manner to both children and their families, providing reassurance and a supportive approach.

Is the service responsive?

Service delivery to meet the needs of local people

CQC Children’s survey 2014

The trust performed about the same as other trusts for all of the questions relating to responsiveness in the CQC children’s survey 2014.

CQC Children’s Survey questions, responsive domain, The Pennine Acute Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did you have access to hot drinks facilities in the hospital?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>8.58</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39. How would you rate the facilities for parents or carers staying overnight?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>7.56</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2. Did the hospital give you a choice of admission dates?</td>
<td>R2</td>
<td>0-7 Adults</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>3. Did the hospital change your child’s admission date at all?</td>
<td>R3</td>
<td>0-7 Adults</td>
<td>9.12</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Key:
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

The trust planned and provided services in a way that met the needs of local people. We found that the trust reviewed data regarding its local population and took this into account when developing services. Data showed that services were responsive to local communities and their
needs

The trust has set up a number of Patient Participation Groups (PPG) which provided an opportunity for local commissioners, providers and members of the public to work together for the benefit of the local area. The PPGs had an input into the co-design and co-production of trust services as well as in other areas of the health economy.

The trust provided us with a patient equality data report in January 2017 which reviewed the trust's responsiveness. The report noted demographic changes in the trust's footprint and looked at performance against those changes.

An example of this was a review of the diversity backgrounds of admitted patients. The report found that generally diversity ratios of those admitted were in line with the general population of the catchment area. The evidence suggests that differing diversity does not affect access to the hospital's services for minority groups.

The report also collected data on age ranges of those who did not attend (DNA) and it revealed that rates of failing to attend outpatient appointments for over 18 age groups were lower, when compared to rates for failing to attend outpatient appointments in under 18's. The trust then used this information to review how it could improve attendance at children's service's outpatient appointments.

Information about the needs of the local population was used to inform how services were planned and delivered. The Neonatal Unit provided care as a level three unit, across the region.

The entrance area to the neonatal ward displayed information about the different job roles and staff uniforms worn on the ward. Inside the entrance to the neonatal unit, a bench style seating area was available for waiting.

On the corridor outside the neonatal unit was a “graduate board”, displaying pictures of children and their development after having been in the unit as babies.

The paediatric ward and areas were child friendly, with ward layout based on different seasons, decorated with related colourful images of flowers and animals.

Meeting people’s individual needs

The service took account of patients’ individual needs. We found an extensive wide ranging support mechanism for a wide range of individual needs.

The trust has developed a tool kit to improving the care and experiences of young people with learning difficulties. The learning disability lead nurse and paediatric speech therapist have led on the development of kit including the introduction of a care pathway for young people with learning difficulties.

We found on inspection that children’s services had access to an alcohol referral service for young people. The service supported patients under 19 who had consumed alcohol and attended hospital intoxicated or had alcohol as a contributing factor in their attendance.

The trust is implementing its mandatory duty to the NHS England Accessible Information Standard for both adults and young people. The standard applies to all health and adult social care organisations. The standard states that the trust has a duty to support access to their services by patients who may have an information and/or communication need, such as blind or deaf patients. The duty also includes making sure that people get information in different formats if they need it, such as large print, braille, embossed, easy read, via email and or visual/British Sign Language (BSL) etc..

An example of how they are implementing the standard is the trust’s communication and information needs passport’ for patients, service users, carers and parents. The passport was launched at an accessible information standard launch event held at North Manchester General Hospital in September 2016. The passport supports health and social care staff to identify the communication and information needs of patients and service users who have a disability,
impairment or sensory loss. The passport enables patients and carers to access and understand the information that they are given.

The trust has set up a multi-faith care after death group. The group was set up to represent the wishes of differing faiths in terms of practices at end of life and in relation to burial. The group is chaired by the Trust Executive Medical Director, to improve the quality of the end of life care services.

The trust provides a Spiritual Care Team (SCT) which meets the emotional, spiritual or religious needs of any children or carers who request support. The service is available, available 24 hours every day, 365 days a year. The service provides access to the three main religious groups in the foot print of North Manchester General: Christian (Church of England, Roman Catholic), Jewish and Muslim chaplains. The service also has approximately 60 volunteers from various faith groups (including one humanist) who visit most wards weekly.

The trust is presently in the process of ratifying a Transgender Policy. The policy covers the needs of transgender patients, including the needs of children and young people, and covers the wider area of transgender issues as well as gender reassignment.

To support the policy, staff are also encouraged in accessing sexual orientation and gender identity training. The trust also provides bespoke access to disability awareness training and deaf awareness training.

The Trust has a Learning Disability Liaison Nurse and a linked strategy which was published in December 2015 and is up for review in 2018. Patients with a learning disability (including children) who are flagged automatically generate an alert to the Learning Disability Liaison Nurse Inbox which is reviewed daily. Staff are also required to follow the Learning Disability Plan and submit an electronic Learning Disability Information Sharing form which is sent to the Learning Disability liaison Nurse this is reviewed daily Monday-Friday.

Staff and patients from the children’s services have access to the Learning Disability liaison nurse who could provide support where needed.

The children’s services had access to an alcohol liaison service which supported children with alcohol misuse problems. The services management sat within the safeguarding team in the hospital.

Specialist therapy services were available on referral when these were required for children on the ward. This included: paediatric physiotherapy, paediatric dietician and social workers. Child and Adolescent Mental Health Services were available for children to access specialist support, when this need was identified. Staff reported that requests following referral were usually followed up the next working day.

We saw a wide range of information leaflets were available in different areas, providing a resource for children, parents and carers. These included: information about registering the birth of a baby; emotional support; counselling services; Patient Advice and Liaison Services and children’s community nursing services.

The children’s unit had a parents’ room, with access to hot drinks, toiletries and meals and drinks available to breastfeeding mothers. A board displayed a variety of information, including details of visiting hours, pharmacy services, parking facilities, play specialists and times of doctors’ ward rounds.

A “Welcome to the Children’s Unit” Book was provided for parents on the children’s ward, which covered all aspects of information on the board, as well as a map of the unit and directions and contact details for other hospitals.

The admissions and discharge lounge was well equipped and had ample information leaflets for parents and carers available.

Some parents / carers told us that they noticed staff being stressed at times when they were low staffed; at those time observations were not always done and parents / carers did not always get any refreshments when they have been there for long periods of time.
There are limited facilities for parents to stay or sleep when they are there for prolonged periods of time, for example, there are bedside beds available for one parent and there is access to a parents’ room with refreshments, and access to a bathroom and toilet.

**Access and flow**

**Neonatal Critical Care Bed Occupancy**

Between May 2016 and April 2017, the trust has seen neonatal bed occupancy fluctuate slightly month on month, with March and April 2017 seeing the highest occupancy levels throughout the period. Occupancy levels were lower than the England average for eight months of the period, and higher than the England average for March and April 2017.

![Critical care bed occupancy - Neonatal](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

We observed the Paediatric Observation and Assessment Unit to be very busy at times. During our inspection we noted that two children in the unit were waiting for longer than eight hours on a trolley to be admitted. One child was waiting for more than 16 hours for a review by a consultant, although this timeframe for consultant review was still within policy, which stated that children in the Paediatric Observation and Assessment Unit require a consultant review within 24 hours.

Staff told us that the Paediatric Observation and Assessment Unit was used at times as a holding area for children awaiting admission to the children’s ward. However, although the Paediatric Observation and Assessment Unit was not staffed sufficiently to carry out regular observations for these patients, we found that no specific patient safety incidents had been reported in relation to this. The trust was also exploring an increase in staffing levels for the Paediatric Observation and Assessment Unit.

Children’s services in Royal Oldham were looking to develop a patient flow coordinator post which would allow the trust to take an overview of patient numbers on a daily and weekly basis. Staff felt this post would be integral to assuring there was decreased risk of bed blockages on wards.

With regards to transition of care, we were not sure if specific pathways were in place for this. However, staff told us that when a 16 year old child had been admitted to an adult ward, some support from the children and young people services could still be provided, for example from a play therapist.

We were told that for long term patients, plans for future transition were considered by consultants and paediatric specialist nurses, however, there was no specific pathway for this in place and the arrangements appeared informal.

**Learning from complaints and concerns**

**Summary of complaints**
We found the children service’s had a low number of complaints. The service treated concerns and complaints seriously and investigated them, but it was not always apparent that learned lessons from the results were shared with all staff.

The trust had a complaints policy and patients who wished to make a complaint were signposted to the Patient Advice and Liaison Service (PALS). However, staff we spoke with told us that they try to deal with complaints informally in first instance to alleviate parents or carers’ concerns.

We did not see or review any documented evidence that indicated learning from complaints.

Between June 2016 and May 2017 there were 22 complaints about Children and Young People’s services (2.7% of all complaints).

The trust took an average of 68 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 here were 13 complaints still open and yet to be completed.

There were 11 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 50%.

Royal Oldham Hospital: There were 11 complaints (50.0%)  
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

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**Is the service well-led?**

**Leadership**

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, it was apparent that many new systems and processes had not yet been embedded.

During our last inspection we found significant concern about how well led the service was. However, during this inspection staff felt that managers and professional leads were supportive and informative. The staff felt proud of their services and despite changes in leadership models felt positive about the organisation and their role in it.

Within the Oldham Care Organisation, the Women’s & Children’s Division had two directorates providing services for children and young people: the Paediatrics Directorate and the Neonatology Directorate. The Women’s & Children’s Division was led by a Divisional Clinical Director, a Divisional Managing Director, a Divisional Director of Nursing – Paediatrics and Neonates. The Paediatrics Directorate and the Neonatology Directorate were led by a triumvirate of a Directorate Manager, a Clinical Director Paediatrics and a Clinical Director Neonatology respectively and a Matron.

Staff told us that senior managers and matrons are visible and they have seen the director of nursing on the ward.

Staff we spoke with felt that managers and professional leads were supportive and staff told us that they felt listened to. However staff said that were frequent occasions when the ward was escalated in line with local policy, but this resulted in no further decision or action from senior staff.

We spoke with staff who told us that the new manager has improved communication, encourages training, focusses on rounding every two hours and the: “hello, my name is…” principle.

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust was committed to improving services by learning from when things go well and when
they go wrong, promoting training, research and innovation.

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. However, we were unsure what the children and young people service’s strategy was and if staff fully understood this.

The trust had a written leadership strategy from 2015-2020 “Saving lives, improving lives” It stated that it wanted to deliver highly reliable care and services, at scale, which are trusted, connected and pioneering. It also stated that its services would be:

• Evidence-based and of the highest quality;
• Highly reliable: high quality whatever the day of the week or hour of the day;
• At Scale: creating benefits for people through standardisation of best practice;
• Trusted: providing safe, effective and compassionate services;
• Connected: seamlessly delivering what matters most to people and communities;
• Pioneering: continuously innovating and improving services.

The values of the trust were displayed in areas throughout the service.

The trust’s vision is to be: ‘A leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.’

The Oldham Care Organisation Priorities 2017/2018 details a vision of: “Saving lives, Improving lives by delivering highly reliable care and services, at scale, which are trusted, connected and pioneering”.

The Oldham Care Organisation Priorities 2017/2018 outlines six Alliance Priorities aimed to make services: evidence-based and of the highest quality; highly reliable (high quality whatever the day of the week or hour of the day); at scale (creating benefits for people through standardisation of best practice); trusted (providing safe, effective and compassionate services); connected (seamlessly delivering what matters most to people and communities) and pioneering (continuously innovating and improving services).

Not all staff were able to describe the vision and strategy to us.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Managers that we met and interviewed were positive about the service and had a “can do”, approach to implementing change. Managers told us they were seeing change since the last inspection the CQC conducted in 2016.

Band 5 nurses in the neonatal unit told us that they felt safe to raise concerns directly with the consultant and they could safely raise concerns with the co-ordinator and ward manager. However, some staff we spoke with in the children’s unit worried about speaking up and were not aware of the trust having a ‘Safe to Speak Up’ guardian.

Neonatal band 5 nurses told us that communication with medical staff on the unit was good. The sister in the neonatal unit explained to us that she receives good support from the Matron and that team working is good on the unit. During a focus group with band 5 neonatal nurses, we were told that they enjoyed working on the ward.

Nursing staff told us that due to low staffing levels they often had to work long times without a
break, which affected staff morale and staff health and well-being.

Staff told us that due to low staffing levels they cannot always provide the best care possible and often worry that they may miss things. Staff told us they feel managers just look at numbers and not skill mix of staff.

Some staff told us that they viewed cross-site working as positive and they would recommend the children and young people service to family and friends.

**Governance**

The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, governance arrangements were not well embedded.

Neonatal Directorate Quality and Performance Meeting minutes from August 2017 had a number of items with regards to 'infection / healthcare associated infections', which had not been changed, or changed significantly on the minutes of the Neonatal Directorate Quality and Performance Meeting minutes from October 2017; from the minutes it was not evident that progress had been made against these items.

From the Neonatal Directorate Quality and Performance Meeting minutes we viewed (August and October 2017), it was unclear who was responsible for taking actions forward and by when.

**Management of risk, issues and performance**

It was not clear if the service trust had effective systems for identifying risks, planning to eliminate or reduce them.

The trust provided us with a spreadsheet ('Paediatric Risks at 1/8/17'), which listed 20 risks. Not all risks were scored or scored correctly and it was not always clear how risks were being mitigated.

We noted that during the Neonatal Directorate Quality and Performance Meeting in October 2017, it was identified that 11 of the guidelines had expired and that three guidelines were about to expire. As the minutes of the meeting did not detail actions, it was not clear who was going to review and update the guidelines and by when.

On the ‘Neonates Improvement Plan TROH V3’ (23 October 2017), a number of actions were documented as: 'Red needs escalating', for example with regards to the milestone/task: ‘Neonatal Clinical Guidelines- All documents identified as RED to be updated’, it was recorded that: “several Red guidelines are still in place - These have been allocated to staff to update. They were discussed at Q&P”. However, it is not clear which staff have been tasked with updating the guidance and by when.

**Information Management**

We noted that the office of the Paediatric Observation and Assessment Unit was freely accessible to patients and parents / carers. Confidential clinical conversations could be overheard and clinical records were freely visible to anyone entering the office. This meant there was a high risk of confidential clinical information being seen or overheard by unauthorised people, including parents and carers.

We observed that the notes trolleys on the neonatal unit and children’s ward were not always kept locked. This posed a risk that unauthorised person could access confidential clinical information.

Staff told us that IT systems were often very slow.

**Engagement**
The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust has participated and set up a Healthier Together programme. The programme looks at collective ways patients and health professionals can improve services. The programme was set up to reflect, where possible, the local population and ensure that those equality groups who are disproportionately affected by the proposals have the opportunity to be involved.

The Trust’s has set up a Children and Young people’s Group (C&YPEG) where children and young people are consulted in the development of paediatric services. Young people share recommendations on the shape of services and sit on interview panels.

Feedback from parents on the neonatal unit was collected using a form in the shape of a baby vest, with smiley faces for parents to indicate their experiences. However, we did not see the results of this feedback.

We were told that the service has good engagement with local schools and displays ‘Please stop smoking posters’ and parents sit on interview panels.

**Learning, continuous improvement and innovation**

The targeting of BAME staff had come about because of lack of leadership in the hospital across BAME staffing groups.

The trust has set up a leadership programme and this includes recruitment and retention, with specific initiatives on workforce race equality.

The programme is open to all staff, but also concentrates on publicising the programme to Black, Asian and Minority Ethnic (BAME) Band 5, 6 and 7 staff.

The director team also wanted to encourage a more diverse staffing group, which reflects its community footprint.

As well as developing awareness of leadership opportunities in the BAME workforce, the trust has also supported a BAME mentoring programme following. The programmes mentors include senior managers as well as the director team.

The service had invested in an Observation and Assessment module and High Dependency Unit, aiming to train two staff per year.

Neonatal band 5 nurses told us that there was funding available for external training, but that they had to complete this within their own time.

The neonatal unit had introduced the ‘Bliss’ accreditation (an accreditation scheme that recognises and rewards neonatal units caring for premature and sick babies that deliver consistent high quality family-centred care and an approach which places parents at the centre of their baby’s care).

The neonatal unit had introduced admission boxes, discharge packs and milestone charts to get parents more involved in baby care, with support from staff.
Facts and data about this service

Urgent and emergency services are provided at Fairfield General Hospital to adults and children primarily in the Bury and Rochdale areas of Greater Manchester, and compliment the urgent and emergency services provided in the region by Pennine Acute Hospitals NHS Trust at North Manchester General Hospital and The Royal Oldham Hospital.

Urgent and emergency services are provided at Fairfield 24 hours a day, seven days a week. Between October 2016/17, there were 68,212 accident and emergency department attendances. This equates to an average of 187 patients a day.

Urgent and emergency services are provided for adults, including hyper-acute stroke assessment. Urgent and emergency services are provided to children up to 18 years of age on a walk-in assessment basis. The hospital does not have a paediatric ward. Children requiring ambulance transport are not treated at this hospital, and those children requiring admission to a paediatric ward are transferred to other centres of care in the Greater Manchester area.

The department has an adult waiting area with a separate triage room, five spaces to treat minor illnesses and injuries, two paediatric side rooms, 16 cubicles to treat patients with major injuries and illnesses, and five resuscitation bays.

The department has a separate waiting and treatment room for the use of patients in the custody of police or prison staff. Another separate room was available for patients experiencing mental health symptoms.

The department’s strategy includes a plan to develop a rapid access treatment service co-located with urgent care and GP streaming services.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff.

Staff underwent a mixture of statutory core and essential job specific related training. Statutory training included a range of subjects as set out in the table below. Training was delivered through a mix of classroom and online training. The trust set a target of 90% completion of mandatory training for each business year from April to March.

Mandatory training completion rates

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in Urgent and Emergency Care are shown below:
Medical and dental staff working in Urgent and Emergency Care failed to meet the 90% target for mandatory compliance for all 16 modules.

Paediatric basic life support and basic life support training had the lowest compliance levels with only 37% and 51% of eligible medical and dental staff having been trained.

By the time of the inspection overall completion of mandatory training had improved and was at 82% for medical staff. Essential job related training for medical staff was 71% against the trust’s target of 90% for year 2017/18.

Nursing and midwifery council registered staff working in Urgent and Emergency Care met the 90% target for mandatory training compliance in three modules (equality and human rights tier 2, hand hygiene assessment and information governance).

Immediate life support and paediatric immediate life support training had the lowest compliance levels with only 33% and 48% of eligible nursing staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
By the time of the inspection, mandatory training rates for nursing staff within Fairfield’s urgent and emergency department had improved to 94% which exceeded the trust’s target. Essential, job specific training for nursing staff, was below the trust’s target at 73%; however, the practice educator told us the figure had been affected by the very recent start of ten new nursing staff that had yet to complete the full range of job specific training. We reviewed the department’s training record system which indicated that future training dates had been booked for all nursing staff for modules that had yet to be completed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training was included in the trust’s mandatory training schedule. Staff we spoke with were able to describe the types of indicators of abuse or neglect that would lead them to consider reporting a safeguarding concern, including the ten new staff members who had just started. Staff were aware of the need to be vigilant and assess for indicators of child sexual exploitation and female genital mutilation. Masterclasses had been delivered by the trust’s safeguarding team which included issues related to female genital mutilation, male circumcision, and domestic abuse.

Training was also provided in the government’s counter-terrorism Prevent Strategy, and referrals for this were managed through the multi-agency safeguarding hub.

Staff were aware of how to find contact details of the trust’s safeguarding team, which were available Monday to Friday between 8am and 6pm, or the local authority’s safeguarding teams where they could obtain further advice if needed. Training had been provided for out of hours bleep holders, and out of hours contact numbers for the local authority were available.

Safeguarding referrals were completed electronically via the trust intranet for review by the internal safeguarding team before transfer to the relevant local authorities. Where necessary, staff were able to contact the on-site social worker, and the dedicated police officer based at the Royal Oldham Hospital.

The electronic patient record system flagged up any previous known safeguarding concerns on the patient’s records. This meant that staff were able to easily identify patients who were previously at risk.

The paediatric waiting area had no ‘direct line of sight’ from the nurses’ station. This meant there were reduced opportunities for staff to observe interactions between children and the adults accompanying them and, as such, restricted the potential for early identification of safeguarding risk factors for children that were not already known to services. An inconsistency in the quality and completeness of the paediatric assessment forms meant there was an over-reliance on individual practitioners’ professional curiosity, which also limited the opportunity for the early identification of safeguarding issues.

Adults attending the department were not routinely asked at triage if they had children or if there were children in the household. This was because there was no relevant prompt on the triage documentation. Further, adults who did not progress to ‘majors’, which could include medically or physically stable adults presenting with substance misuse or mental ill-health were not given a care plan. This meant there was a reliance on staff having a professional curiosity to identify potential safeguarding children risks.

Adults who were seen in ‘majors’ were given a care plan which prompted the practitioner to ask about caring responsibilities; however, the prompts were not explicit in differentiating between an adult with caring responsibilities or an adult without responsibilities who lived in a household that included children.

However, we did not see any evidence to indicate that staff had missed or failed to identify safeguarding issues in any specific cases. Where child protection concerns had been identified,
referrals for children and young people were made quickly within the department. Referrals were made directly to children’s social care teams with the guidance of a ‘trigger list’ of presenting concerns, and were shared with the trust's safeguarding team.

There was no paediatric ward at the hospital, which meant that children under 16 years of age, who needed to be admitted, were transferred to another hospital in the region. Transitioning children, between 17 and 18 years old, were treated as adults and did not have a paediatric assessment completed. The accident and emergency paper records did not therefore specifically alert practitioners that the patient was a child for those being admitted to the ward. However, the daily surgical and medical in-patient report identified any relevant children admitted to adult wards. In line with the trust’s guideline and flowchart for wards admitting children aged 16 to 18 years of age to adult wards, we saw evidence that daily reviews for any such children had been undertaken by the relevant matrons. These checked that the facilities and ward environment were suitable for the child involved.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical and dental and nursing and midwifery council registered staff working in Urgent and Emergency Care is show below:

NB – data from the following teams have been used for the below as the trust didn’t include a specific Urgent and Emergency Care core service for the training data supplied in the RPIR:

BD215 - Medical Staff - UCC (Rochdale), BD311 - Urgent Care Centre (Rochdale), BE404 - Urgent Care Teams, CB100 - Urgent Care Mgmt (Bury), CB101 - Urgent Care Mgmt (North), CB102 - Urgent Care Mgmt (Oldham), (Oldham), CB205 - Medical Staff - A&E (Bury), CB210 - Medical Staff A&E (North), CB225 - Medical Staff - A&E (Oldham), CB305 - Accident & Emergency (Bury), CB307 - Accident & Emergency (North), CB309 - Accident & Emergency (Oldham), CB322 - A&E - ENPs (North), CB324 - A&E - ENPs (Oldham), CSPR - Accident and Emergency (SPRs)

Medical and dental staff working in Urgent and Emergency Care at the trust didn’t meet the 90% target for any of the safeguarding modules. Level 2 adults and children both had 85% compliance with 74 of the 87 eligible staff members completing the training in both these modules.

Compliance for level 3 adults was the lowest, with only 44% of required staff members completing the training.

Data that the trust provided at the time of the inspection demonstrated that 88% of medical staff had completed adult safeguarding level two training and 86% of medical staff had completed children safeguarding level two training. This was against the trust’s target of 90% for years 2017 to 2018.
Nursing and midwifery council registered staff working in Urgent and Emergency Care at the trust exceeded the 90% completion target for both level 2 adults and children Safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Data available at the time of the inspection demonstrated that 99% of nursing staff had completed safeguarding adults level two training and safeguarding children level two training. Seventy-seven per cent of eligible staff had completed safeguarding adults level three training, and 76% of band six and above nurses had completed safeguarding children level three training. We saw evidence that future training dates had been scheduled for remaining staff that had not yet completed the training. The trust’s safeguarding lead held level five safeguarding training.

It was intended that level three children’s training would be extended to all band five nurses working with children across the trust. This was awaiting a decision from the trust board.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection.

The department and equipment used within it were visibly clean and tidy during our visit. Domestic cleaning services were contracted to an external supplier. The domestic cleaning and housekeeping staff were visible in the department throughout our visit. We viewed the daily cleaning logs which confirmed the areas that had been cleaned on a daily basis. Domestic staff told us the logs were reviewed regularly each week by the contractor's supervisor; however, the log sheets were inconsistently signed by the supervisor.

There were sufficient numbers of antibacterial hand gel dispensers located throughout the department and we observed staff using these. However, we observed there were no hand gel dispensers within the paediatric waiting area.

We observed staff following accepted infection control and hygiene procedures, including washing hands and having ‘arms bare below the elbow’. There were sufficient quantities of personal protective equipment such as gloves and aprons throughout the department and within each bay. We observed staff using protective equipment appropriately.

In the 12 months prior to the inspection, the department had reported no cases of methicillin resistant staphylococcus aureus or C.difficile.
Environment and equipment

The adult waiting area was visibly clean and included adequate seating. Male and female toilets were available and were clean. Well stocked vending machines provided access to drinks and snacks, and a range of leaflets were available.

The 'majors' and 'minors' illness areas were laid out to provide line of sight for all bays and cubicles from the central nurses station. The department was colocated with the x-ray area.

The viewing room, which was used for family and carers to be able to spend time with deceased relatives, did not provide a sensitive environment. The room appeared to have been previously used as a wet room with tiling on the floor and walls. Temporary disposable curtains were drawn around the walls of the room, which only minimally softened its appearance.

In the triage and assessment area, we observed the door between the triage room and the ambulance corridor was left open whilst triage was being undertaken. We were told by the staff member that this was because the room became very warm. However, as the ambulance corridor was also accessible to members of the public, this represented a risk to the privacy of patients within the triage room.

The paediatric waiting area was suitably decorated with children's themes. It was visibly clean and tidy, although we noted one toy that appeared to be broken. The waiting area was accessed via a secure call bell system remotely operated from the nurses' station. This meant that inappropriate access to the area, which also included the minor illness area, was appropriately restricted.

There was no direct 'line of sight' from the nurses station to the paediatric waiting area, which increased the risk that staff may not be aware of the deterioration of a child in the waiting room.

A call buzzer system was in the room for relatives to alert staff. However, when we asked the carer for one child in the waiting area about this, they said they would not know how to contact anyone and, as such, would 'run back to triage'. The carer only 'guessed the emergency buzzer was on the wall'.

We raised this with senior managers who told us that any acutely unwell, or lone, children would be placed directly into one of the two paediatric triage side rooms and would not be asked to wait in the waiting area. This was in line with the department's triage pathway. Senior staff also noted that, although no staff were permanently based in the paediatric waiting area, there was regular review of the area by staff.

There was direct access from the paediatric treatment area to the x-ray department. This meant that children were not required to travel through the adult areas to be x-rayed.

Resuscitation trolleys were located in the paediatric, majors, and resuscitation areas. All trolleys were appropriately sealed and tagged. With approximately 14 to 17 resuscitation trolleys in the department, we checked a random sample. Equipment stored within the trolleys was within the manufacturers recommended expiry dates. Electronic portable equipment including the defibrillators were observed to be working. Daily checks had been carried out appropriately and these were recorded in the log. We found no evidence that daily checks had been missed.

Portable electrical equipment throughout the department was appropriately tested and maintained. We reviewed a range of equipment in all areas of the department and found none which had passed the recommended testing date.

The urgent and emergency department had a designated mental health assessment room. This was opposite one of the nursing stations to assist with ongoing observations of patients awaiting, and undergoing, assessments. The room offered privacy for the assessment of patients with suspected or actual mental health needs.

The room had two doors - one with an observation panel to assist with observation of patients with a privacy setting controlled by staff. One of the doors opened outwards which prevented patients from barricading themselves in the room. The room had a strip alarm all around the room so that staff and patients could summon assistance, and included three heavy chairs designed to be weighted to prevent patients from picking them up and throwing them. Two electrical sockets were
in the room; however, we were assured these had been disconnected from the mains electrical supply. The room had no natural light but there was a pleasant mural of a woodland scene on one wall to help make the room calming and less clinical.

The mental health assessment room did not contain any ligature points. For example, places to which a cord, rope or other material could be attached for the purposes of hanging or strangulation. However, the toilet that patients used when being assessed in the mental health assessment room was next to a room which contained a number of ligature points on the toilet and sink fixtures and fittings. If a patient presented as a serious risk of self-harm, mental health staff could escort them in the toilet or provides the patient with disposable equipment to use instead. This helped to keep patients who were intent on self harm safe from hurting themselves.

There was no separately designed room within the paediatric department for children experiencing mental health symptoms; however, staff told us such children would be treated within one of the paediatric side rooms.

There was a health based place of safety near to the mental health wards at Fairfield Hospital managed by the local mental health NHS trust. This was used by the police to bring people in from public places for an assessment under section 136 of the Mental Health Act. Police would usually only bring people to the emergency department on a section 136 if they also required medical attention.

Assessing and responding to patient risk

The urgent and emergency department had a process in place for triaging walk-in patients. Suitable patients were triaged to the GP streaming service which operated Monday to Friday between 6pm and 10pm, and between 4pm and 10pm at weekends. Two ‘corridor’ nurses were in place to manage the flow of patients and triage of patients brought in by ambulance.

Patients who were suspected of having infection were clearly identified with an orange wristband, which assisted in the early implementation of the sepsis six tool kit. Patients with head injuries were identified with a yellow wrist band, while those with allergies were provided with a red wrist band.

The department offered a hyper-acute stroke service between 7am and 10.45pm. Patients suspected of having a stroke were transferred immediately into the resuscitation area for onward computed tomography scanning. This enabled the specialist team of a stroke nurse, middle grade doctor, and consultant to quickly decide on whether or not the patient required thrombolysis treatment (the use of medicine to dissolve and disperse blood clots).

The department used a national early warning score system in conjunction with the department escalation plan to ensure that deteriorating patients were appropriately escalated to medical staff. The Royal Manchester Children's Hospital early warning score re system was used in the paediatric department. However, the department did not have a dedicated paediatrician.

Risk assessments for pressure ulcer and falls assessments were carried out. The skin bundle was implemented for any patients at risk of developing a pressure ulcer, which included the provision of pressure relieving mattresses for patients who needed them. Patients at risk of falls were identified by the use of a golden leaf symbol.

Care plans were in place for all patients within the ‘majors’ and resuscitation areas.

Acuity tools were in place, and were checked when patients moved between the ‘majors’ and ‘minors’ areas. The divisional director of nursing told us that a new staffing rota tool was due to be implemented in January 2018 which measured patient acuity needs.

At the time of the inspection, only doctors or consultants were able to agree and sign-off patients for discharge from the department. This provided assurance that patients were medically fit for discharge from the department.
Staff in the urgent and emergency department had a triage tool to support them to identify and assess patients with suspected mental health needs. This included the assessment of risk that the patient may pose to themselves or others. Patients were assessed as low, medium, or high risk.

Until recently patients presenting with low risk mental health symptoms were assessed, referred back to their GP and signposted with leaflets or to other organisations. However recent practice changes meant that all patients were referred to the specialist mental health liaison staff called the rapid assessment, interface, and discharge team. Staff in the emergency department could refer directly to the team and did not have to wait for a doctor’s assessment.

Records showed that in one case, staff took appropriate action to inform the police and then make regular contact when a patient known to mental health services had presented to the emergency department and had left without receiving medical attention. Calls to the police were only stepped down when staff received assurances that the patient was safe in line with the trust’s policy for missing and absconded patients.

Arrangements were in place for staff from the rapid assessment, interface and discharge team to follow up patients who presented with self harm, including ongoing contact by the team, communication with the patient’s community mental health staff or through a formal agreement with the local Samaritans for patients to receive a follow up welfare call by them.

**Accident and Emergency Survey**

The trust scored “about the same” as other trusts for all five of the 2014 survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the accident and emergency staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q6. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q7. From the time you first arrived at the accident and emergency Department, how long did you wait before being examined by a doctor or nurse?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. In your opinion, how clean was the accident and emergency Department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. While you were in the accident and emergency Department, did you feel threatened by other patients or visitors?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC – Accident and Emergency Survey (01/01/2014 - 31/03/2014)

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

The trust did not meet the standard for 12 months over the 13 month period between August 2016 and July 2017.

Performance improved from May 2017 onwards where performance was closer to the standard than in previous months during the period.

In July 2017 the median time to treatment was 65 minutes compared to the England average of 60 minutes.

**Time to treatment all patients between August 2016 and July 2017 at The Pennine Acute Hospitals NHS Trust**
Median time from arrival to initial assessment (emergency ambulance cases only)
The median time from arrival to initial assessment for this trust was worse than the overall England median for 11 of the 12 months between August 2016 and July 2017.

In July 2017 the median time to initial assessment was 8 minutes compared to the England average of 7 minutes.

Royal College of Emergency Medicine guidance indicates that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Patients attending the Fairfield department unplanned (walk-in) were triaged by a nurse following registration. In the eleven records we checked during our inspection, all but one patient had received an initial triage assessment within 15 minutes of arrival and registration. The average waiting time in the records we checked was nine minutes. Patients we spoke within the waiting area commented that they felt triage had been ‘quick’ and ‘efficient’.

Patients were ‘streamed’ as part of the triage process to the appropriate area of treatment. This included streaming to the GP service which had recently been introduced. The GP streaming service operated Monday to Friday between 6pm and 10pm and between 4pm and 10pm at the weekend. The long term plan was to develop a ‘fit to sit’ rapid access and treatment area collocated with the GP streaming service.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust Fairfield General Hospital

Between September 2016 and August 2017 there was a relatively stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Fairfield General Hospital. With the exception of January 2017 where there was a slightly higher proportion of ambulance journeys with a turnaround time over 30 minutes.

January 2017 also saw the highest number of turnaround times over 60 minutes throughout the period.

Ambulance: Number of journeys with turnaround times over 30 minutes - Fairfield General Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Fairfield General Hospital

(Source: South East Coast Ambulance Service – collated on behalf of North West Ambulance Service - Ambulance Turnaround Times)

The urgent and emergency service collected data on a separate measure of handover times greater than thirty minutes. This was measured from the time of arrival of the patient by ambulance to the service’s acceptance of responsibility for the patient. This showed that, between October 2016 and September 2017, Fairfield recorded a total of 1773 ambulance arrivals with handover greater than 30 minutes or where no timestamp had been recorded. This equated to an average of 7% of ambulance arrivals and 49 cases per month.

We spoke with two ambulance staff. They told us they had no concerns relating to handovers which they said were good and patients were admitted quickly. The staff also noted that patients were triaged in a room rather than on the corridor which maintained patients’ privacy and dignity.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

Between 6 June 2016 and 29 May 2017 the trust reported 2,890 “black breaches” across all its urgent and emergency services. The number of black breaches increased in December 2016 and peaked at 509 breaches in January 2017. The number of breaches has since fallen, except in April 2017 where numbers increased again slightly.
At location level, between October 2016 and September 2017, Fairfield had a total of 112 black breaches which equated to an overall average of 9 per month. The number of black breaches peaked during the winter period with 31 breaches in December 2016 and 45 breaches in February 2017, which was in line with the trend for black breaches across the trust.

Nurse staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

During our inspection, the urgent and emergency services department had sufficient staff available to fulfil the requirements of each shift. Nurse staffing rotas were completed four weeks in advance. The lead nurse (matron) told us a staffing tool was used to determine staffing levels in line with patient acuity; however, this did not always recognise the staffing skill mix required and this increased the time taken to produce the rotas.

We reviewed the rotas for October and November 2017. These included at least one band seven nurse per shift, with two during the daytime; three band six nurses per shift; and the remaining compliment of nursing staff were band fives.

The department was appropriately staffed over three separate shift patterns. The early shift, between 7.30am and 3.30pm, was staffed with 13 qualified nurses and three healthcare assistants. The late shift, between 1.30pm and 9.30pm, was staffed with 14 qualified nurses and four healthcare assistants. The night shift, between 9.15pm and 8.45am, was staffed with 11 qualified nurses and one healthcare assistant.

At the time of the inspection, the department employed 10.5 whole time equivalent band seven nurses, 17 band six nurses and 31 band five nurses. The department had recently employed ten new nursing staff members who were undergoing induction at the time of the inspection. One advanced practitioner, at band 8a, had also recently started in the department.

The department had four vacancies for band five nurses but recruitment was ongoing with candidates shortlisted for interview.

The trust has reported the following planned and actual staffing figures for nursing and midwifery council registered staff working in Urgent and Emergency care for the period December 2016 to May 2017.
<table>
<thead>
<tr>
<th>Month</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>250.83</td>
<td>276.24</td>
</tr>
<tr>
<td>January 17</td>
<td>257.39</td>
<td>276.24</td>
</tr>
<tr>
<td>February 17</td>
<td>258.46</td>
<td>276.24</td>
</tr>
<tr>
<td>March 17</td>
<td>269.46</td>
<td>275.24</td>
</tr>
<tr>
<td>April 17</td>
<td>269.60</td>
<td>275.24</td>
</tr>
<tr>
<td>May 17</td>
<td>272.27</td>
<td>283.86</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Nursing vacancy rates in the Fairfield urgent and emergency service were low.

Between June 2016 and May 2017, the trust reported an average vacancy rate of 6.8% for nursing staff in urgent and emergency care;

- Fairfield General Hospital: 2%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The urgent and emergency department at Fairfield reported 18.6 whole time equivalent nursing council registered and other clinical services vacancies in August 2017. Ten new nursing staff had been recruited and started in September 2017 which reduced the department’s vacancies to 8.6 whole time equivalent.

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing staff in urgent and emergency care;

- Fairfield General Hospital: 0.6%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.2% for nursing staff in urgent and emergency care, which is higher than the trust target of 4.6% for sickness rates.

- Fairfield General Hospital: 4.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Sickness rates were monitored at a weekly meeting by the assistant directors of nursing. Reviews were undertaken to understand reasons for sickness absence, and reasonable adjustments that could be made to encourage staff to return to work. These included amending individuals’ working patterns, phased reduction of working hours, and referral of staff to the trust’s occupational therapy teams via the occupational health scheme. In September 2017, sickness rates for nursing staff were 3.3%.

**Bank and agency staff usage**

Between June 2016 and May 2017, 34 (approximately one per cent) qualified nursing shifts were filled by bank or agency staff. This equated to an average of 2.8 shifts per month. There were 380 (approximately 14%) unfilled qualified nursing shifts; an average of 32.6 unfilled shifts per month.
In the same period, 349 (approximately 39%) healthcare assistant shifts were filled by bank or agency staff, which equated to an average of 29 shifts per month. There were 205 (approximately 23%) unfilled healthcare assistant shifts; an average of 17 unfilled shifts per month.

The lead nurse explained there had been a number of vacancies and maternity leave in the department which had since been mitigated by the recruitment of further nursing staff.

The department only used NHS Professionals or existing staff on overtime to cover shifts.

**Medical staffing**

At Fairfield at the time of the inspection there was 16 hour consultant cover between 9am and midnight seven days a week. The department had seven registrars (of which four were substantive), which ensured middle grade rota cover, and 16 junior doctors. The trust had an ongoing recruitment process in place.

The trust has reported the following planned and actual staffing figures for medical and dental staff working in urgent and emergency care for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Whole Time Equivalent in post</th>
<th>Whole Time Equivalent planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>75.54</td>
<td>104.10</td>
</tr>
<tr>
<td>January 17</td>
<td>76.54</td>
<td>104.10</td>
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<tr>
<td>February 17</td>
<td>75.04</td>
<td>104.10</td>
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<tr>
<td>March 17</td>
<td>75.96</td>
<td>104.10</td>
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<tr>
<td>April 17</td>
<td>77.56</td>
<td>104.10</td>
</tr>
<tr>
<td>May 17</td>
<td>77.56</td>
<td>104.10</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 26% for medical and dental staff in urgent and emergency care;

- Fairfield General Hospital: 21%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

More recent information showed the urgent and emergency department at Fairfield reported 1.5 whole time equivalent medical staff vacancies in September 2017. This had reduced to 1.1 whole time equivalent by October 2017.

**Turnover rates**

Between June 2016 and May 2017 the trust reported an average turnover rate of 3.5% for medical staff in urgent and emergency care;

- Fairfield General Hospital: 3.4%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

More recent figures showed the department had no turnover for both September and October 2017.
Sickness rates
Between June 2016 and May 2017, the trust reported an average sickness rate of 1.5% for medical staff in urgent and emergency care which is better than the overall trust target of 4.6% for sickness rates.

- Fairfield General Hospital: 0.8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

In September 2017, the department at Fairfield reported a 0.17% sickness rate.

Bank and locum staff usage
Between 1 May and 31 October 2017, agency locum doctors covered a total of 582 shifts, covering consultant, specialist training and speciality doctor roles. In the same period trust bank locum doctors covered 97 shifts in the department.

(Source: Additional Provider Data Request (DR98 Medical Locums)

Staffing skill mix
Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 84 whole time equivalent staff working in Urgent and Emergency Care at The Pennine Acute Hospitals NHS Trust.

We found that at the time of the inspection there was 16 hour consultant cover between 9am and midnight seven days a week. The middle grade rota was also fully covered.

Records
Staff kept appropriate records of patients’ care and treatment. Adult records were clear, up-to-date, and available to all staff providing care. However, there was variability in the quality and completeness of paediatric records.

The urgent and emergency service used both electronic and paper records. Paper records were scanned onto the electronic system, while the hard copy was retained for six months. Discharge letters were sent electronically through the system to each patient’s GP within 24 hours of discharge.
We reviewed eleven sets of records. The name and grade of the medical professional reviewing each patient, the time of the review, allergies, and notes were signed and dated in all eleven sets of records.

Only one out of the eleven records indicated that a patient had not been triaged within 15 minutes of arrival; however, this target had only been missed by five minutes. Six out of eleven records showed that the patient was seen within one hour of presenting to the department. In ten out of eleven records we found evidence of local senior review and referral to an appropriate specialist.

The records indicated that pain relief was prescribed and administered appropriately in four cases where it was required, and in one case where antibiotics were required these were also prescribed and administered quickly.

We saw evidence that staff had assessed patients’ pain scores and revised pain scores following pain relief, early warning scores, falls risk and pressure ulcer risk.

One patient, living with dementia, had a do not attempt cardiopulmonary resuscitation decision in place, and this had been discussed with the patient’s family.

We also reviewed a random selection of 12 paediatric attendance records from the two weeks prior to the inspection for children under 16 years of age. The records included a newly developed paediatric assessment form. The form had been in use for approximately six months; however, there was an inconsistency in the quality and completeness of the forms we reviewed. Of the twelve records, only two assessments were fully completed and three did not have an assessment completed at all.

**Medicines**

The service prescribed, gave, recorded and stored medicines well.

Medicines were stored appropriately in locked cupboards within the medicines storage room. The shift co-ordinator held the keys for the medicines’ cupboards.

We checked a random sample of medicines which were all found to be within the manufacturer’s recommended expiry dates. We also reviewed a random sample of the department’s controlled drugs; stock tallied with the entries in the controlled drugs register. The register was appropriately completed with two signatures, and we found no discrepancies. Stock was checked daily against the register by a band seven nurse and one other nurse, and weekly by the department manager. We also checked a random selection of medicines and controlled drugs within the locked storage cupboards in the resuscitation room. Similarly we found no discrepancies with stock, the register, or medicines outside of the manufacturers recommended expiry dates.

We also reviewed a random selection of medicines that required refrigerator storage. These were within the recommended expiry dates. We reviewed the fridge maximum and minimum temperature logs which were checked daily and fully completed. All entries we viewed showed that the fridge temperatures remained within the recommended ranges.

A patient group directive, signed by a doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription only medicines to patients using their own assessment of patient need, without referring back to a doctor for an individual prescription. Patient group directives were used in the department, but only by emergency nurse practitioners. We reviewed the competency certificates for emergency nurse practitioners to administer a range of medicines. These confirmed that staff were competent and up to date with best practice guidance.

The department employed a medicines management assistant to manage the department’s medicines stocks, to reconcile patient medication, to support staff in obtaining prescriptions and ‘to take out’ medicines for patients being discharged. This has reduced the waiting time for patients to receive their medicines and had a positive effect on the timeliness of patient discharge.

Tamper proof bins were used for the disposal of drugs and there was an appropriate system in place for destroying old or unused medicines.
However, within the medicine’s storage room, we found an unlabelled tamperproof bag of medicines that was not locked in the cupboard. We raised this with staff who arranged for immediate disposal of the medicines as, following investigation, staff were not able to determine where the medicines had come from.

**Incidents**

The service managed patient safety incidents appropriately.

Staff were able to describe the types of incidents that may occur within the department, including near misses. Staff recognised incidents when they occurred and reported them appropriately. The trust had recently introduced a new incident reporting system and provided training on it to staff. Seventy-two hour reviews were undertaken for any incident reported with an impact rating above moderate. Divisional managers escalated relevant reviews to the care organisation leads for a decision on whether or not the incident would be declared as a serious incident.

Senior managers within the department reviewed, investigated and shared lessons learned from incidents with the whole team and the wider service where appropriate. Managers shared lessons learnt in a variety of methods; through staff handover safety huddles, staff meetings, news bulletins and by email. This meant there were opportunities for all staff to receive shared learning, including those returning from leave or on night shifts. Staff confirmed to us learning was shared for significant incidents affecting the department or service, although they did not always receive individual feedback on incidents they personally reported.

When things went wrong, staff apologised and gave patients honest information and suitable support in line with the principles and requirements of the duty of candour.

Following the introduction of the care organisation model, significant progress was made by the department to eliminate 12 hour trolley breaches. The department had no 12 hour breaches between February 2017 and October 2017.

Between June 2017 and September 2017, Fairfield urgent and emergency services reported four serious incidents. Two of these resulted in the death of a patient, one resulted in severe harm, and one resulted in moderate harm. All four incidents trigged a response by the trust under the duty of candour.

The lead nurse and consultant met monthly to review the care provided to patients who had subsequently died. This included review of the records of patients who had died in the department as well as those who had recently received care in the department but died out of hospital following discharge. Each review looked at the quality of the patient’s records, staff use of departmental policies and protocols, the medicines prescribed and administered and the quality of nursing care provided. The outcome and learning from these reviews was fed into the care organisation’s mortality and morbidity meetings.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Urgent and Emergency Care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 533 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England.
between August 2016 and July 2017.

The breakdown of incident types was:

- Eight treatment delay meeting the criteria
- Five diagnostic incident including delay meeting the criteria (including failure to act on test results)
- Three medication incident meeting the criteria
- Two sub-optimal care of the deteriorating patient meeting the criteria
- One all other categories

The 514 incidents, which related to 12 hour trolley breaches in accident and emergency, that were pending review at the time we obtained the data, have since been reviewed, downgraded and closed in conjunction with the local clinical commissioning groups.

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)

Safety thermometer

The service used safety monitoring results well. Staff collected safety thermometer information and used information to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month; a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new catheter urinary tract infections between August 2016/17 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment for adults based on national guidance and evidence of its effectiveness.

The urgent and emergency services department used pathways that were evidence based in line with National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These included fractured neck of femur, sepsis and the recognition of stroke.

Staff were able to quickly access policies and procedures for the department, which were held on the trust’s intranet.

The department participated in the national Royal College of Emergency Medicine audits so it could benchmark its practice against other emergency departments.

Records showed that staff from the rapid assessment, interface and discharge team carried out comprehensive mental health assessments and provided guidance and support to emergency department staff on how patients presenting with mental health needs could be treated.
signposted, admitted to an acute or mental health inpatient bed, or discharged. Staff were also supported with the management of intoxicated patients with a flowchart diagram, which asserted the need for patients to be coherent and understand the need for assessment prior to being seen by the team.

However, the use of formal written pathways, protocols, and risk assessments was less evident in the paediatric area, which was highlighted by the inconsistency of completion of the paediatric assessment tool. Staff told us there had been some resistance to the implementation of the tool due to a perceived lack of co-production. The lack of guidance had resulted in reliance on organisational culture and the understanding that all practitioners know what to do when faced with different scenarios.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients’ religious, cultural, and other preferences.

We observed housekeeping staff regularly providing patients with food and drink within the department as part of the hourly comfort rounding process. Families and carers were also able to access the drinks trolley outside the formal rounds.

A range of hot and cold foods and sandwiches were available to suit patients’ needs, including vegetarian, Halal and Kosher options.

Patients who required assistance were provided with a red tray. This meant that nursing and healthcare assistant staff could easily identify those who needed help.

Speech and language assessments were undertaken for patients who were experiencing symptoms of stroke.

Staff used a malnutrition universal screening tool appropriately to assess patients who were at risk of malnourishment.

The waiting room included well stocked vending machines for people to access while waiting to be seen.

In the CQC Accident and Emergency Survey, the trust scored 5.9 for the question “Were you able to get suitable food or drinks when you were in the accident and emergency Department?” This was about the same as other trusts.

*(Source: CQC Accident and Emergency Survey 2014)*

**Pain relief**

Staff gave patients pain relief when required. Pain relief, including paracetamol and ibuprofen, could be provided by emergency nurse practitioners under the patient group directives. Records we reviewed showed that pain relief was prescribed and administered in a timely way when it was required and appropriate. We also observed staff providing two patients in the waiting room with pain relief medication while waiting for treatment.

In the CQC Accident and Emergency Survey, the trust scored 6.0 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q30. Do you think the hospital staff did everything they could to help control your pain? 7.5 About the same as other trusts
Q33. Were you able to get suitable food or drinks when you were in the accident and emergency department? 5.9 About the same as other trusts

(Source: CQC Accident and Emergency Survey 2014)

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service participated in the Royal College of Emergency Medicine audits between 2015 and 2017. Although the service achieved variable results, internal audits undertaken in 2017 showed improvement in standards.

The audits against the Royal College of Emergency Medicine’s clinical standards enabled the department to benchmark itself nationally and more locally against the trust’s other emergency departments. Where the audits highlighted areas of concern, the department had taken action to address these.

For example, in relation to the audit on severe sepsis and septic shock, the department had appointed a sepsis lead. It also introduced and implemented an amended version of the Bristol emergency department safety checklist; the sepsis six bundles; mandatory training for staff in the sepsis six programme and use of the bundles; and, the purchase of a blood gas analyser for the department to enable staff to carry out serum lactate measurements (a test for how well oxygen is reaching the body’s cells).

The department subsequently undertook an internal audit against the Royal College of Emergency Medicine’s standards. Although there was still room for improvement to meet the Royal College of Emergency Medicine’s targets, the audit showed significant improvements in seven out of the eight standards.

In response to the Royal College of Emergency Medicine’s audit on the monitoring of vital signs in children, the department introduced and implemented the Manchester children’s hospital early warning score system to the paediatric department. The department undertook a full set of observations for each child, and had employed a paediatric nurse within the department. We saw evidence of this, which included age specific guidance, within the department. The department also had at least one advance paediatric life support trained nurse and doctor on every shift.

The department subsequently undertook monthly internal audits from March 2017. The initial report in May 2017 indicated that staff completed an early warning score for all children in the sample that required it. The audit report highlighted some remaining issues in the correct recording and calculation of the score; however, further audits between July and October 2017 showed significant improvement in these areas.

In response to the Royal College of Emergency Medicine’s audit on venous thromboembolism risk in lower limb immobilisation in plaster cast, the department carried out venous thromboembolism assessment, which was recorded on the electronic records. The department was working with an orthopaedic surgeon to discuss the implementation of providing prophylactic anticoagulant medicine to all patients being put into a cast.

Royal College of Emergency Medicine Audit: Severe sepsis and septic shock
Fairfield General Hospital:

In the 2016/17 Royal College of Emergency Medicine audit for severe sepsis and septic shock, Fairfield General Hospital failed to meet any of the standards. The hospital was in the lower UK quartile for six measures and between the upper and lower quartile for the remaining two measures.
The measures for which Fairfield General Hospital performed in the lower quartile were:

- **Standard 1**: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival (21.3%)
  
- **Standard 2**: Review by senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED (46.8%)
  
- **Standard 3**: O2 was initiated to maintain SaO2>94% (unless there is documented reason not to): Within one hour of arrival (0.0%)
  
- **Standard 4**: Serum lactate measured: Within one hour of arrival (23.9%)
  
- **Standard 6**: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: within one hour of arrival (12.8%)
  
- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival (2.2%)

*(Source: CQC Insight) Royal College of Emergency Medicine*


In the 2015/16 Royal College of Emergency Medicine audit for vital signs in children, Fairfield General Hospital was in the upper quartile compared to other trusts for one of the six measures and was in the lower quartile for four of the six measures.

The measure that performed in the upper quartile was:

- Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non training grade doctor). (100%)

The measures that performed in the lower quartile were:

- Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score (20.8%) and capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest (5.7%)
  
- There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present) (28.9%)
  
- There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases (13.3%)

*(Source: Royal College of Emergency Medicine)*

**Royal College of Emergency Medicine Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast 2015/16 Fairfield General Hospital**

In the 2015/16 Royal College of Emergency Medicine audit for lower limb immobilisation in plaster cast, Fairfield General Hospital performed:

- For the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, the hospital had a sample size of 0 cases therefore the measure was NA.
  
- In the lower quartile for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 100% in 100 cases.
Royal College of Emergency Medicine Audit: Procedural Sedation in Adults (2015/16)  
Fairfield General Hospital  
In the 2015/16 procedural sedation in adults audit, Fairfield General Hospital was in the upper quartile for one measure, the lower quartile for four measures and the middle quartiles for the remaining two measures.  
The measure that performed in the upper quartile was:  
- Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:  
  a. Return to baseline level of consciousness  
  b. Vital signs within normal limits for the patient  
  c. Absence of respiratory compromise  
  d. Absence of significant pain and discomfort  
  e. Written advice on discharge for all patients (34.1%)  
The measures that performed in the lower quartile were:  
- Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status (0.0%)  
- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities (70.2%)  
- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG (3.5%)  
- Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area (14.0%)  

(Source: Royal College of Emergency Medicine)  

Unplanned re-attendance rate within 7 days  
Between August 2016 and July 2017, the trust’s unplanned re-attendance rate to accident and emergency within seven days was worse than the national standard of 5% and worse than the England average. In the latest period, July 2017, the trust’s performance was 10% compared to the England average of 7.7%.  

Unplanned re-attendance rate within 7 days - The Pennine Acute Hospitals NHS Trust  

![Graph showing the unplanned re-attendance rate within 7 days from August 2016 to July 2017. The rates range from 5% to 11%, with a peak around July 2017.]
The urgent and emergency service at Fairfield did not meet its target of less than five per cent unplanned re-attendances within seven days. The rate between September 2016 and October 2017 was consistently worse than target at an average of 7.1%.

As part of a commissioning for quality and innovation goal to reduce the frequency of re-attendance of patients with mental health symptoms by 10%, staff from the emergency department and the rapid assessment, interface and discharge team had started to meet up regularly to help better support people who frequently attended the emergency department, including patients with mental health needs and patients with a personality disorder.

As a result, staff had written to 20 regularly attending patients to the emergency department, to arrange meetings with them to see if their needs could be met better elsewhere in the health and social care system. Patients had then been referred for more active follow up by community alcohol services or the local improving access to psychological therapies services. This had shown a reduction an initial attendance from these patients.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance.

The department had a practice educator to support the training needs for staff, and to oversee the training processes for new and existing nursing staff.

The department had an induction programme for new staff. This included a two-week corporate induction following by a four week period, which included two days of classroom training per week with three days of supernumerary experience working in the department. Each new staff member was allocated a preceptor and was expected to complete and sign off job competencies as part of the induction programme.

Job specific competencies were reviewed yearly by management staff as part of the staff appraisal and personal development review process. Staff self-assessed their own competencies and these were then reviewed and countersigned by their manager. We reviewed four staff files which included fully completed competency reviews.

The practice educator supported nursing staff with their nursing and midwifery council revalidation. A process was in place to notify the practice educator if a staff member was due to revalidate.

Life support training was provided to staff in the department. At the time of the inspection and reflecting the number of eligible staff for each module, 86% of staff had completed basic life support and 65% had completed basic paediatric life support; 24% had completed advanced life support and 57% had completed advance paediatric life support; and, 20% had completed immediate life support and 73% had completed immediate paediatric life support. We reviewed the departments training records system and we observed that all eligible staff that had not yet completed the relevant modules had a future training date booked.

One student nurse told us they had both a paediatric and adult mentor who were approachable, reviewed their competencies, and provided opportunities to shadow in areas such as the resuscitation room. The nurse confirmed they had received practice supervision and that the team in the department were supportive.

The directorate manager told us the department shared training with staff in the medical assessment unit. This enabled staff in both areas to mix and learn together. It was described as a positive experience for staff.

Major incident training was included in the departments induction programme for new staff. Training was delivered over two days by the trust’s chemical, biological, radiological, and nuclear lead. The course prepared staff for the use of respiration equipment and protective suits, and
reviewed the hospital’s major incident plan and staff roles within this. The chemical, biological, radiological, and nuclear lead was in the process of reviewing and updating the trust’s plan to reduce the overall size of the document, and to individualise it for the needs of the Fairfield site.

Appraisal rates

Appraisals were carried out over a rolling twelve month period against the trust’s annual target of 90%. At the time of the inspection, 74% of eligible nursing staff in the urgent and emergency services department had received an appraisal. We saw evidence that future dates had been scheduled for those staff members that had yet to receive their appraisal.

NB– data from the following teams have been used for the below as the trust didn’t include a specific Urgent and Emergency Care core service for the appraisal data supplied in the RPIR:

352 BD115 - UCC Clerical (Rochdale), 352 BD311 - Urgent Care Centre (Rochdale), 352 BE404 - Urgent Care Teams, 352 CB100 - Urgent Care Mgmt (Bury), 352 CB102 - Urgent Care Mgmt (Oldham), 352 CB105 - A & E Clerical Support (Bury), 352 CB110 - A&E Reception (North), 352 CB113 - A & E Clerical (Oldham), 352 CB305 - Accident & Emergency (Bury), 352 CB307 - Accident & Emergency (North), 352 CB309 - Accident & Emergency (Oldham), 352 CB322 - A&E - ENPs (North), 352 CB324 - A&E - ENPs (Oldham)

Between June 2016 and May 2017, 69% of staff working within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%.

The 69% appraisal rate applies to nursing and midwifery council registered staff, additional clinical services staff, allied health professionals, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

At Fairfield General Hospital 26% had an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff attended shift handover meetings, also known as safety huddles, twice a day at 7.30am and 9.15pm. This ensured that relevant patient information, safety information, and learning was shared with staff at the start of each shift.

Staff from the department attended the multidisciplinary meetings each weekday on the medical assessment unit. Representatives from the consultant group, junior doctors, nursing physiotherapy, and occupational therapy, pharmacy and care of the elderly teams attended

We observed effective multidisciplinary working between all groups of staff.

The department’s staff had a close working relationship with the thrombolysis team and the stroke lead nurse, and were involved in the development of the hospital’s stroke pathway.

Staff worked closely with, and received specialised support from the rapid assessment, interface and discharge mental health nursing team and were able to directly refer appropriate patients requiring mental health assessment from triage to the team. The team consisted of a team of psychiatric nurses, with two psychiatric nurses on duty on each shift.

Older adult liaison nurses provided mental health input to older adults, and alcohol liaison nurses supported the care and treatment of patients with alcohol addiction and alcohol related conditions.
Psychiatric medical input was provided on an on call arrangement via the rapid assessment, interface and discharge team staff to on call consultant psychiatrists working in the local mental health NHS trust. Staff within the psychiatric liaison team and emergency department commented that the service worked well together to meet patients’ physical and mental health needs and valued each other’s input.

Seven-day services

The urgent and emergency service at Fairfield was open 24 hours a day, seven days a week. X-ray facilities were colocated to the department and could be accessed during the same operational hours. Pharmacy, physiotherapy, and pathology services were also available seven days a week.

A hyper-acute stroke service was available between 7am and 10.45pm. This was led by a consultant, middle grade doctor and specialist stroke nurse. Telemetrics were used to enable the stroke consultants to remotely review computed tomography scans for patients with suspected stroke if the consultant was not on site at the time.

Patients presenting with mental health issues could be referred to the on-site rapid assessment, interface and discharge team for assessment. The team worked 24 hours a day, seven days a week.

Health promotion

Staff in the urgent and emergency department promoted smoking cessation to every patient admitted who smoked.

Future plans for health promotion included the potential installation of a health promotion screen within the waiting area, and leaflets for self-help.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff were aware of the Mental Health Act 1983 and the Mental Capacity Act 2005 including the deprivation of liberty safeguards.

We observed staff taking consent appropriately. This included both verbal and implied consent. Staff understood their duties to ensure patients had capacity to consent. Where a patient potentially lacked capacity, nursing staff escalated this to the medical team to carry out a formal assessment of the patient’s capacity. Training was also provided in relation to do not attempt cardiac resuscitation orders.

We did not observe any decisions being made specifically in a patient’s best interests where they lack capacity, or where a do not attempt cardiac resuscitation had been put in place; however, staff were aware of the relevant processes. Decisions to apply for a Deprivation of Liberty safeguarding order were only made following formal assessment and decision by the medical team.

The practice educator told us that training in the Mental Capacity Act and deprivation of liberty safeguards was included in the departments safeguarding mandatory training. The department also provided training on the management of patients who presented with mental health symptoms, including the missing person’s policy, and patients living with dementia. However, the trust’s mandatory training tracker identified a separate Mental Health Act and Mental Capacity Act level one training module which had yet to be implemented. Sixty eight nursing and health care assistant staff were identified as requiring this training.
Dynamic risk assessments were carried out for any patients presenting with mental health symptoms by the rapid assessment, interface and discharge team. Patients who, following assessment, were identified as needing a mental health specific bed were kept in the department until a formal mental health act assessment was carried out.

The urgent and emergency services department had a dementia link nurse, who also provided training to staff; 93% of nursing and healthcare assistant staff had completed the level one dementia awareness training. The department implemented the ‘this is me’ information leaflet for patients living with dementia and supported John’s Campaign.

**Mental Capacity Act and Deprivation of Liberty training completion**
Data for this metric was not provided.
*(Source: Trust Provider Information Return P14/P49)*

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**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion.

We observed kind, caring, and compassionate interactions between staff and patients. Two patients told us staff were kind and caring and that they had been treated well. We observed one staff member treating a patient, who was living with dementia, very patiently and compassionately. One patient told us they had a good experience and they would recommend the department. This was in line with National Institute for Health and Care Excellence Quality Standard 15 Statement 1: “Patients are treated with dignity, kindness, compassion, courtesy, response, understanding, and honesty.”

A named nurse was allocated to each bay and their names were clearly displayed on a board within each cubicle in the department. We observed staff introducing themselves to patients by name in line with National Institute for Health and Care Excellence QS15 Statement 3: “Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.”

Patients’ privacy and dignity was maintained with cubicle curtains consistently drawn while patients were receiving care and treatment, or when friends and family were present. This was in line with the Royal College of Emergency Medicine Emergency Department Care (2017) Quality Standard QS4.

Senior leaders expressed their views that the organisation should support terminally ill patients and their families in whichever way possible. For example, the department had arranged a wedding for a terminally ill patient within three hours. This included obtaining cake and flowers, and arranging for the patient’s pet dog to be brought in.

**Friends and Family test performance**

Between July 2016/17, the trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was consistently worse than the England average. In the latest period, June 2017 the trust’s performance was 83.7% compared to the England average of 87.6%.

However, Fairfield performed better than the trust average with the percentage of patients that said they would recommend its urgent and emergency service. In June 2017, 87% of patients said they would recommend the service. The figure was 86% in July, 89% in August, and 86% in September.

The department had introduced an electronic system for collecting friends and family feedback. This sent a text message to patients’ mobile telephone to enable them to respond. The system also enabled comments to be made. The nurse lead for the department reviewed all feedback.
received and highlighted positive feedback on an information board within the department. Negative feedback was reviewed, assessed and learning shared at staff meetings, the safety huddle and by email.

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**Accident and Emergency Friends and Family Test Performance - The Pennine Acute Hospitals NHS Trust**

![Graph showing performance over time.

(Source: NHS England Friends and Family Test)](https://example.com/graph)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Staff were aware of the impact on patients and carers as a result of the care and treatment provided. Staff undertook comfort rounds every hour to check on patients who had been in the department longer than four hours. This was to ensure their needs were met and included checking that patients could reach their possessions and the call bell. This was in line with National Institute for Health and Care Excellence QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety. The department was able to chaperone any patient that requested it.

Patients experiencing mental health symptoms were treated within a designated side-room next to the nurses’ station. Staff referred patients appropriately to the on-site rapid assessment, interface, and discharge team. This meant that patients with mental health and alcohol or substance misuse problems were supported with early psychiatry liaison and assessment.

We spoke with one patient who was awaiting a mental health assessment. The patient was very complimentary about their experience of attending the emergency department for their emotional distress and spoke highly of staff that they had spoken with during triage, in the department and in the rapid assessment, interface and discharge team. The patient felt they had received appropriate care and support for their mental and emotional wellbeing and described staff and the service as ‘fantastic’.
A band three staff member supported bereaved families and rang them to ensure they had received appropriate information and support both on the day of their relative’s death and the day after.

A number of staff members in the department told us how they had supported the emotional needs of an elderly patient who had attended the department. The patient was living with dementia and was becoming increasingly distressed and agitated while awaiting assessment and treatment. Staff brought a music player into the department and encouraged the patient to sing along and dance with support. Staff also provided the patient with lunch at the nurses’ station. Staff told us this reduced the patient’s anxiety to a point where the patient told staff they did not want to leave following treatment.

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

Staff involved patients and those close to them in decisions about their care and treatment.

We spoke with four patients in the waiting room who had already been through the triage assessment. All four patients told us they had been informed of what tests or treatment would need to be undertaken and what they were waiting for. However, not all patients were aware of how long they would need to wait for the next stage of treatment.

The nurse lead for the department told us a decision had been made not to display the current waiting time in the waiting area. The decision was taken in an attempt to reduce patient dissatisfaction while waiting but was mitigated by triage staff informing patients individually how long they may need to wait before receiving treatment. Of the four patients we spoke with in the waiting room, two had not been informed of how long the wait would be.

We observed the triage assessment of seven patients. Staff took clear histories from patients and their carers, undertook appropriate assessments, and informed them of the next steps.

**Accident and Emergency Survey 2014**

The results of the CQC Accident and Emergency survey 2014 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>2014 RAG</th>
<th>Trust 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Were you told how long you would have to wait to be examined?</td>
<td>About the same as other trusts</td>
<td>4.44</td>
</tr>
<tr>
<td>Q10. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>About the same as other trusts</td>
<td>8.15</td>
</tr>
<tr>
<td>Q11. While you were in the accident and emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>7.97</td>
</tr>
<tr>
<td>Q12. Did the doctors and nurses listen to what you had to say?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>About the same as other trusts</td>
<td>8.60</td>
</tr>
<tr>
<td>Q15. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>About the same as other trusts</td>
<td>8.70</td>
</tr>
<tr>
<td>Q16. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>About the same as other trusts</td>
<td>7.42</td>
</tr>
<tr>
<td>Q17. While you were in the accident and emergency department, how much information about your condition or treatment was given to you?</td>
<td>About the same as other trusts</td>
<td>8.58</td>
</tr>
<tr>
<td>Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>About the same as other trusts</td>
<td>7.84</td>
</tr>
<tr>
<td>Q20. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Question</td>
<td>2014 RAG</td>
<td>Trust 2014</td>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>About the same as other trusts</td>
<td>7.76</td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity while you were in the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>8.54</td>
</tr>
<tr>
<td>Q13. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>About the same as other trusts</td>
<td>7.04</td>
</tr>
<tr>
<td>Q22. If you were feeling distressed while you were in the accident and emergency department, did a member of staff help to reassure you?</td>
<td>About the same as other trusts</td>
<td>6.08</td>
</tr>
<tr>
<td>Q24. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.26</td>
</tr>
<tr>
<td>Q25. Before you left the accident and emergency department, did you get the results of your tests?</td>
<td>About the same as other trusts</td>
<td>8.24</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.72</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>About the same as other trusts</td>
<td>8.49</td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>About the same as other trusts</td>
<td>5.22</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>About the same as other trusts</td>
<td>4.66</td>
</tr>
<tr>
<td>Q39. Did hospital staff take your family or home situation into account when you were leaving the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>4.67</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>About the same as other trusts</td>
<td>5.30</td>
</tr>
<tr>
<td>Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the accident and emergency department?</td>
<td>About the same as other trusts</td>
<td>6.99</td>
</tr>
<tr>
<td>Q43. Overall... (please circle a number)</td>
<td>About the same as other trusts</td>
<td>7.80</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care and treatment in a way that met the needs of local people. People attended the service primarily from the local population in the Bury area, although the service also received patients from further afield including Rochdale.

The department’s facilities and premises were appropriate for the services provided. However, the service was working with the local clinical commissioning group and the GP provider to plan and develop improvements to the department, including the development of a rapid access and treatment ‘fit to sit’ service.
The service was in the process of developing and implementing a winter pressures plan in conjunction with other departments in the hospital. This included opening 10 beds, and moving elective patients to discharge as efficiently as possible to free up beds for patients needing admission. The plan modelled capacity against demand with a view to matching nursing and medical staff to expected peaks in demand towards January 2018. The integrated discharge team attended bed escalation and care optimisation meetings to identify areas of support needed to effectively discharge patients.

Direct referral to the alcohol liaison service was available between 9am and 5pm.

The department worked with the rapid community response team with the aim of avoiding unnecessary admissions to hospital. The team, which also worked in collaboration with local housing services, consisted of an emergency nurse practitioner, occupational therapist, doctor, and social worker. The lead nurse told us of an example where a volunteer had worked with the team to secure housing support for a patient who regularly attended the department. The team's actions resulted in a reduction in the number of times the patient returned to the department.

The urgent and emergency services department had implemented the trust’s helpline facility. This provided a dedicated telephone number for each ward or department that was responded to by a dedicated staff nurse. The aim of the service was to respond to, resolve, and if necessary escalate any immediate concerns from patients.

The lead nurse told us the helpline facility had been in place for approximately six months with less than ten calls received during that time, which the lead nurse believed was due to the quality and level of information provided by staff to patients during their admission. This was reflected in the comments we received from patients who confirmed they had been kept up to date with relevant information during their wait and their treatment.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The lead nurse told us that staff were trained and encouraged to ask patients “What matters to you?”. This helped staff to understand patients’ individual needs and how they could be best supported.

A range of patient information leaflets were available within the department. The majority of these were in English; however, the service had undertaken work to understand the most common language requirements of the local population. Copies of leaflets in other languages were available online for staff to print off when required.

Staff understood the importance of not relying on patients’ families or carers to interpret important information and conversations. Interpretation services were available by telephone, and face-to-face when appropriate; this included British sign language. One hospital staff member was able to translate Polish, while another was able to communicate using sign language.

Speech and language assessments were carried out in the department as required for patients presenting with the symptoms of stroke. This enabled staff in the department to provide appropriate fluids and nutrition to these patients.

Patients with a diagnosis of dementia were identified by the use of a blue wristband and the forget me not symbol. The department held a memory box to support patients who were living with dementia while in the department. This was used in conjunction with the principles of the care of the frail and elderly model which had been introduced.

The hospital volunteer radio station also included a ‘Dementia Hour’ each day, where the station took requests direct from the wards and from the department.

A separate access to the x-ray suite from the paediatric treatment area meant that children did not have to be taken through the adult areas of the department.
Patients with mental health needs presenting within the emergency department were referred and seen by trained mental health staff working in the rapid assessment, interface and discharge team, including mental health staff trained to work with older adults with organic mental disorders such as those living with dementia.

Staff in the team had access to the mental health NHS trust patient records to check if patients were already known to mental health services. This enabled staff to identify the support and treatment patients were given by community mental health services to ensure patients received appropriate and continuous treatment.

A relatives’ room was available for families and carers of a deceased relative. The room was located next to the viewing room and enabled families to be supported in a private area away from the main areas of the department.

**Accident and Emergency Survey**

The trust scored “about the same” as other trusts for the three Accident and Emergency Survey questions relevant to the responsive domain.

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<td>9.00</td>
<td>About the same as other trusts</td>
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(Source: CQC Accident and Emergency Survey 2014)

**Access and flow**

People could access the service when they needed it. Waiting times for triage were in line with good practice and decisions to admit, treat, and discharge patients were improving.

During the inspection, we observed the flow of patients and reviewed current information on waiting times. We reviewed waiting times recorded in eleven sets of records. The average waiting time from arrival in the department to initial triage was 9 minutes. The average waiting time from arrival in the department to being seen by a doctor was 63 minutes. The monthly median time from arrival to initial triage within 15 minutes between October 2016 and September 2017 was between six and eight minutes.

The urgent and emergency services department introduced a navigator role staffed by a senior member of the department staff. The navigator provided overall co-ordination of the department, tracked patients' length of stay in the department and escalated any potential breaches to the lead nurse or on-call manager/director in line with the department’s escalation policy. The navigator had access to the hospital’s bed request system, which provided a clear snapshot of available beds and enabled them to make requests for specialised beds such as bariatric, infection control, or pressure relieving beds.

Daily bed meetings were attended by representatives from across all areas of the hospital including community representatives and the hospital social worker. We observed one meeting at 9am, chaired by the Director of Nursing. Staff at the meeting identified any departmental issues, including staff shortages. A proactive approach was taken to sharing and moving staff to support areas experiencing shortages.

Staff identified areas of bed capacity, including one ‘golden patient’ from each ward that was expected to be discharged by 10am each morning. The lead nurse for the urgent and emergency service told us the ‘golden patient’ programme ensured that at least eight beds were available for patients waiting to be admitted to a bed from the department each morning. Bed capacity within the community was also highlighted in the meeting.
The department liaised with the occupational therapy navigator to improve flow out of the department. The navigator worked with a physiotherapist and nurse between the hours of 8am and 8pm, seven days a week. The team were able to liaise with the community crisis team, social services and the local authority to arrange packages of care or equipment for patients in the department who required support in the community but did not require admission to hospital.

Plans were in the process of being developed to provide a ‘fit to sit’ rapid access and treatment centre for the department. It was envisaged this would be led by a senior doctor and senior nurse. The centre, which would include a seating area and up to four cubicles would be colocated with the GP streaming service.

The department was looking at other areas for improving flow. This included the use of an emergency care intensive support team to provide advice on streaming, direct referral to ambulatory care, and the introduction of an amended version of the Bristol emergency department checklist to quickly identify the relevant needs of patients in the waiting room.

The mental health rapid assessment, interface and discharge team operated 24 hours a day, seven days a week. The team had a target response time of seeing 95% of patients within one hour from the time of the referral to responding and beginning the mental health assessment. Records we reviewed showed that staff in the team in most cases responded to a request for mental health assessment and involvement within one hour from the time of referral. Where team staff could not meet the response, an explanation was given in the records.

Where there were delays in processing patients in the emergency department on the grounds of mental health beyond the recommended four hours waiting times, staff told us this was usually due to the need for the patient to undergo a Mental Health Act assessment or if a child or young person needed a specialist children’s and adolescent mental health bed. This was beyond the full control of the staff in the emergency department or the rapid assessment, interface and discharge team, as it usually related to awaiting attendance from the approved mental health professional to coordinate the Mental Health Act assessment and assessing doctors external to the hospital or sourcing an appropriate bed.

The day before the inspection, we looked at records relating to a young person who had a significant wait in the emergency department while a specialist children’s and adolescent mental health bed was found. The chief operating officer of the hospital had escalated the delays in this case to senior managers of the mental health trust to try to avoid unnecessary delay, and an appropriate bed was secured for the patient at eight hours, avoiding a 12-hour breach.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the Accident and Emergency.

The trust failed to meet and subsequently breached the standard for each month during the period September 2016 to August 2017.

From March 2017 onwards performance against this metric has shown a general trend of improvement, peaking in May 2017 but still showing an upward trend towards the standard for June 2017 to August 2017.

Throughout the period the trust’s performance, although consistently below the England average, has followed a similar trend to it.

**Four-hour target performance - The Pennine Acute Hospitals NHS Trust**

<table>
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<tr>
<th></th>
<th>This Trust</th>
<th>England Avg.</th>
<th>Standard</th>
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Although the urgent and emergency services at Fairfield did not meet the four-hour standard for the period October 2016/17, from February to October 2017 there was a consistent improvement in performance from 83% to 94%. This was in line with the trust’s external target trajectory for improvement between April and October 2017. This target had been agreed with the Greater Manchester Health and Social Care Partnership. The department also achieved a two-day period in July with no breaches.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between September 2016 and August 2017 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was higher than the England average.

Performance against this metric showed a trend of improvement from October 2016 onwards where the percentage of patients waiting between four and 12 hours has decreased steadily, moving closer in line with the England average. May 2017 saw the lowest percentage of patients waiting between four and 12 hours throughout the period.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Pennine Acute Hospitals NHS Trust**

(Source: NHS England - Accident and Emergency Waiting times)
The urgent and emergency services at Fairfield showed a similar steadily decreasing trend in the number of patients waiting in the department between four and 12 hours. This resulted in a drop from 429 patients waiting for this period in December 2016 to 80 patients in October 2017.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from September 2016 and August 2017, 721 patients waited more than 12 hours from the decision to admit until being admitted.

The highest numbers of patients waiting over 12 hours were in October 2016 with 129 patients, January 2017 with 125 patients and February 2017 with 113 patients.

For October 2016 and February 2017 the trust had the highest number of patients waiting over 12 hours out of all NHS acute trusts.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
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</thead>
<tbody>
<tr>
<td>Sep-16</td>
<td>1137</td>
<td>36</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1633</td>
<td>129</td>
</tr>
<tr>
<td>Nov-16</td>
<td>1623</td>
<td>84</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1569</td>
<td>86</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1404</td>
<td>125</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1122</td>
<td>113</td>
</tr>
<tr>
<td>Mar-17</td>
<td>931</td>
<td>73</td>
</tr>
<tr>
<td>Apr-17</td>
<td>899</td>
<td>40</td>
</tr>
<tr>
<td>May-17</td>
<td>683</td>
<td>9</td>
</tr>
<tr>
<td>Jun-17</td>
<td>763</td>
<td>1</td>
</tr>
<tr>
<td>Jul-17</td>
<td>824</td>
<td>22</td>
</tr>
<tr>
<td>Aug-17</td>
<td>675</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: NHS England - Accident and Emergency Waiting times)

Between October 2017 and February 2017, a total of 49 patients at Fairfield waited more than 12 hours from the decision to admit until being admitted. However, from March 2017 to October 2017, no patient waited longer than 12 hours to be admitted at Fairfield.
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

Between September 2016 and July 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was higher than the England average. However performance against this metric has shown a trend of improvement with the median percentage decreasing slightly from its peak in December 2016.

From May 2017 onwards performance has become more in line with the England average. In the latest period, July 2017, the median percentage for the trust was 3.5%, compared to the England average of 3.4%

Percentage of patient that left the trust without being seen - The Pennine Acute Hospitals NHS Trust

The urgent and emergency service at Fairfield consistently met the 5% target of patients leaving the department without being seen. From a maximum of 3.9% of patients leaving the department in January 2017 there was an overall downward trend to 1.1% of patients leaving in October 2017. This equated to an average monthly rate of 2% of patients leaving the department which was better than the overall trust performance.

Median total time in Accident and Emergency per patient (all patients)

Between September 2016 and July 2017 the trust’s monthly median total time in Accident and Emergency for all patients was consistently higher than the England average. May 2017 was the month where the trust’s median total time in Accident and Emergency of 151 minutes was closest to the England average of 148 minutes.

Median total time in Accident and Emergency per patient - The Pennine Acute Hospitals NHS Trust
Between November 2016 and October 2017, the median total time in the department for patients who were admitted was 232 minutes. For patients who were not admitted the median total time in the department was 146 minutes.

**Accident and Emergency Survey**

The trust scored “about the same” as other trusts for the three Accident and Emergency Survey questions relevant to the responsive domain.

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<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Accident and Emergency Survey 2014)

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Between June and September 2017, the hospital received 11 complaints about care and treatment provided by the Fairfield urgent and emergency service. Complaints were co-ordinated by the trust’s complaints team and sent to the department for investigation. The lead nurse, practice educator and other senior nursing staff in the department investigated complaints.

Feedback was provided individually to any staff member involved in the complaint in a supportive manner with any relevant training needs identified. Learning from complaints was shared more widely with the team at team meetings, within daily safety huddles (and repeated for seven days to ensure the majority of staff had the opportunity to receive the learning), in newsletters and emails. Learning from safeguarding concerns was also shared in the seven-minute briefings, and in the quarterly safeguarding bulletin. Safeguarding was included as a standing agenda item at the monthly nursing forum.
Summary of complaints
Between June 2016 and May 2017 there were 149 complaints about Urgent and Emergency Care services (18.3% of all complaints).

The trust took an average of 63 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 39 complaints still open and yet to be completed.

There were 93 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 62%.

Fairfield General Hospital: There were 38 complaints (25.5%)
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership
The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Since the last inspection, the trust has undergone significant restructuring with the introduction of the local care organisation model. The Bury and Rochdale care organisation leaders, who have been in post since January 2017, had responsibility for the Fairfield site. The care organisation was led by a team consisting of a managing director/chief operating officer, a medical director, a director of nursing and a finance director. The urgent and emergency service at Fairfield was part of the Bury Division of Integrated Care and was led by a lead consultant and lead nurse.

The departmental, directorate and divisional leaders we spoke with understood the challenges facing the service, which included staffing levels, incidents, and complaints. The leaders were also able to clearly describe the actions that had already been taken, or were planned to be taken, to meet these challenges.

All staff spoke positively about the introduction of the care organisation model, and the majority were aware of who the care organisation and directorate leaders were. Senior staff, including the core organisation, divisional and directorate staff were visible on the unit for walk rounds and also undertaking clinical duties when needed. Staff told us that the senior team in the care organisation were approachable. We observed senior leaders within the unit working closely with the teams in an approachable manner. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standard 14.

Vision and strategy
The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff.

Senior staff within the urgent and emergency service were able to describe the department’s strategy for improving performance within the department.

The strategy included assessment of staffing level, the implementation of the GP streaming initiative, and plans to introduce an advanced nurse practitioner role to ‘float’ and support the team.

The strategy also focussed on flow out of the department including the further implementation of the ‘golden patient’ initiative to provide up to eight beds each morning to transfer patients out of the department, and the expansion of the acute medical unit to be able to accept more patients from the department.

Leaders had a clear understanding of the direction the department was taking including further physical development of the environment and service. Future plans included development of a
rapid assessment and treatment service collocated with the GP streaming service and a third paediatric triage room.

Staff we spoke with told us there had been significant improvements already because of the department’s strategy and, as a result, there had been no 12-hour breaches in the department since February 2017. An escalation policy and protocol was in place and used within the department, which required the director on call to attend the department to manage the delay, speak with, and apologise to, any patient that had been waiting for longer than six hours.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with were positive about the culture in the department which had improved over the past year.

Staff were motivated, proud and felt supported by their managers to provide good quality care. The culture encouraged openness and honesty at all levels in the department. Staff were supported to report incidents and feedback to individuals was provided in a positive way. We saw no evidence of a ‘blame culture’ in the department. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standards including QS12, QS18, QS21, and QS50.

Junior nursing and medical staff we spoke with told us they felt listened to and felt able to speak up to the senior staff including pausing any procedures if they had any potential safety concerns. One staff member spoke positively about the support they received from the lead nurse during an extended period of absence through ‘keeping in touch meetings’. The staff member was provided with shadowing opportunities as part of their return to work.

Staff were aware of, and had received training, in the Duty of Candour (the Duty). Senior members of staff were aware of the Duty’s triggers of medium or severe physical or psychological harm or death. Nursing staff, including the ten new nursing staff members we spoke with, were aware of the principles of the Duty to be open and honest when things go wrong.

Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The accident and emergency services at Fairfield were provided in the emergency and urgent care directorate. The directorate formed part of the Bury division of integrated care, which, alongside the Heywood, Middleton, and Rochdale division of integrated care, was led by the Bury and Rochdale care organisation leadership team.

The care organisation structure had been in place since January 2017. It was supported by a clear governance structure and clear lines of accountability for staff at all levels. Staff at all levels in the urgent and emergency services department spoke positively about the introduction of the care organisation model.

Staff were clear about their roles within the new structure, what they were accountable for, and to whom. There was a clear escalation and governance committee structure in place with lines of sight to the care organisation director team. This included quality, risk and operational performance committees, including mortality and morbidity review following the death of patients who had received treatment in the department.

There was an improvement in a number of performance measures for the urgent and emergency services since the implementation of the care organisation model, such as the elimination of
12-hour trolley waits. However, the leaders acknowledged there was still room for further improvement to meet key national targets.

The trust has signed up as a partner agency (through the Greater Manchester acute trust chief executive's group) to the local mental health crisis care concordat agreement and action plan. The concordat was a national agreement between services and agencies involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people get the help they need when they were having a mental health crisis.

The mental health rapid assessment, interface and discharge team had a clear service specification which clearly set out how mental health staff should jointly work with acute trust staff.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Divisional, directorate and department leaders were able to describe, understood and had oversight of the risks and issues affecting the urgent and emergency service at Fairfield.

Risk was monitored through the divisional quality assurance and risk committee, which met monthly to review the urgent and emergency services departmental risks. Risks with a score higher than six were escalated to the monthly quality, patient experience, and clinical effectiveness committee.

The care organisation assurance and risk committee oversaw risks scoring 10 or higher. These were fed into the care organisation’s board assurance framework and risk register and enabled the care organisation to develop and set its assurance statements for the group risk and assurance committee.

We reviewed the care organisation’s risk register, which set out clear escalation pathways. The register included risks that reflected those we were told about by the lead nurse, the directorate and divisional leads. These included risks relating to staffing levels, incidents and complaints. We also reviewed the risk register for the urgent and emergency service at Fairfield. This included risks we expected to see.

Both registers identified the key control measures and gaps for each risk, the likelihood and impact of each risk, the assurance measures and gaps, an action plan for each risk, and an assessment of the ‘risk tolerance level’. However, it was not clear when each risk had been entered onto the register and, as such, it was not possible to accurately determine if control measures and action plans had been identified in a timely way.

Performance was monitored monthly through divisional management meetings. These fed into the divisional operations and performance committee, through the operations, performance and finance information committee, and similarly into the care organisation assurance and risk committee.

Performance information for the department was monitored on a monthly basis against national and NHS Improvement targets and trajectories. A dashboard enabled senior staff to compare performance of the individual departments, and the urgent and emergency service across the trust.

Learning from risks, incidents, complaints and safety alerts was shared with staff in a variety of methods including email, newsletters, and the daily safety huddles. Relevant information was repeated in safety huddles for seven days to ensure that the majority of staff received the information.

The department had rolled out Sepsis Six care bundle training in line with NICE Guideline NG51 Sepsis: recognition, diagnosis and early management. The Sepsis Six aimed to implement three diagnostic and three therapeutic actions within one hour of a diagnosis of potential sepsis. These included monitoring of oxygen levels, fluids and urine output, measurement of lactate levels and
the commencement of blood culture tests and antibiotics. The department had achieved 97% training compliance for all eligible nursing staff.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan and staff were aware of where the plan could be accessed. The department and hospital responded to a recent major incident in Manchester with the on-call manager and senior team called in. A silver and gold command was set up and the department received two walk-in patients, while the hospital’s mortuary responded to assist the forensic mortuary at Oldham. Staff told us that patients already in the waiting room, who were able to, voluntarily left to reduce the demand for staff. The trust provided support and counselling services for staff involved. Debriefing sessions were subsequently arranged which included learning from the event.

Information management

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems. However, staff usage of the systems was not always compliant with the requirements of security safeguards.

Performance information was collected and analysed by the department and used to develop and support the services the department offered. This included the collection of data to support national audits and surveys including those by the Royal College of Emergency Medicine, the Safety Thermometer, the NHS Friends and Family Test, and interactions with the ambulance service.

Performance data was benchmarked against urgent and emergency services in the trust’s other care organisations, against the trust performance as a whole, and where appropriate against national standards.

Staff had access to the relevant information needed to care for their patients. However, numerous staff told us they had experienced issues with responsiveness of the trust’s information management and technology systems at busy times of the day. Staff anecdotally referred to problems experienced in accessing the blood test system at busy times of the day; however, they were unable to provide direct examples of when delays in the system directly affected patient safety. However, this was a known issue on the risk register. The nurse lead recognised that delays in obtaining test results had the potential to delay patient admission or discharge. This was a known issue on the risk register.

However, the departmental ‘navigator’ staff member provided mitigation for this through liaising directly with the pathology lab to obtain and chase results when necessary. This meant that, although a source of frustration, staff were unable to provide us with any examples of where responsiveness of the systems had directly affected patient care.

Staff were not always compliant with the requirements of the information management system security safeguards. We observed computer terminals logged on and displaying patient information without staff in attendance. We raised this with the directorate manager and lead nurse who acknowledged computers should be locked when not being used. The lead nurse and director of nursing for the care organisation took immediate action to obtain screen privacy filters to prevent patient information being viewed inappropriately.

Engagement

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services.

The department participated in the NHS Friends and Family scheme, using an electronic text messaging feedback system. Volunteers also spoke with and collected Friends and Family
information and patients’ experiences within the department from those that were unable or did not have access to the electronic messaging system.

The lead nurse reviewed all comments from patients. Positive comments were displayed on the departmental information board, and factors contributing to negative comments were shared within the department’s safety huddles. The assistant directors of nursing and lead nurse also reviewed patient comments recorded on the NHS Choices website and, where contact details were available, contacted patients to clarify and to understand any negative concerns expressed.

Patient comment cards were available in the department.

The department participated in the trust’s 1000 voices events which aimed to engage and capture staff views and ideas on the trust’s reorganisation and improvement programme. A monthly Team Talk was facilitated by directors to deliver important messages. Staff also received updates through departmental newsletters and emails.

The care organisation also organised an engagement event for staff on World Stroke Day, which included free lunch.

The division and department engaged in and promoted the ‘Happy, Healthy, Here’ programme. The programme aims to promote and improve the health and wellbeing of staff.

There was engagement with the staff side unions.

The divisional director of nursing attended the operational pressures escalation level two conference calls. The calls brought together representatives from local care home providers, the clinical commissioning group and the urgent and emergency department to discuss how patients could be moved through the system safely.

The department had been nominated in the staff awards for best department and consultant.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There was a culture of supportive learning and improvement embedded in the department. All managers within the department were involved in the review and investigation of incidents and complaints and learning from these was shared with staff through a range of media including written and face-to-face communications. The lead nurse, who had themselves previously been a practice educator, worked in close collaboration with the current practice educator to deliver learning and training to new and existing staff.

One staff member provided an example of learning from an incident where the department had subsequently changed its missing person policy.

However, one staff member told us they felt that opportunities for study days, beyond those provided for mandatory training, were limited due to lack of funding. Another staff member expressed their view that continual professional development was restricted as a result of funding issues.
Medical care (including older people’s care)

Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all trust services)

**Fairfield General Hospital** provides cardiology outpatients, inpatient and day case services with cardiology interventions and diagnostic procedures being carried out in The Silver Heart Unit.

Respiratory outpatient and day case services are also provided on the Fairfield site. This includes integrated lung cancer clinics that form part of the integrated network lung cancer pathway and provide diagnostic services.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 84,153 medical admissions between June 2016 and May 2017. Emergency admissions accounted for 43,207 (51.4%), 1,779 (2.1%) were elective, and the remaining 39,167 (46.5%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 45,655
- Gastroenterology: 12,034
- Clinical Haematology: 11,993

(Source: CQC Insight)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to staff and had made sure most staff completed it. Staff completed mandatory or core training and essential job related training which was specific to their job role. All new starters were included in mandatory training figures, this meant new starters on a ward could significantly impact on the mandatory training rates.

On three of the wards that we visited, we found that mandatory training rates were at or above 90%. On one of the wards that we visited mandatory training rates had improved from 29% compliance to 87% compliance since January 2017 and on some wards there was an education lead for the ward to support mandatory training. The hospital managers told us that the overall mandatory training rate for medicine was at 91% compliance at the time of the inspection.

Mandatory training completion rates

The trust set a target of 90% completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff working in the Medicine division are shown below:
Medical and dental staff in the medicine division failed to meet the 90% target for mandatory training compliance for all of the 16 modules.

Paediatric basic life support and basic life support training had the lowest compliance levels with only 36% and 52% of eligible medical and dental staff having been trained.
Nursing staff in the medicine division met the 90% target for mandatory training compliance in two modules (waste management and infection prevention non-patients).

Immediate life support and paediatric immediate life support training had the lowest compliance levels with only 44% and 48% of eligible nursing staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

**Safeguarding training completion rates**

There were effective systems and processes in place to safeguard patients. Staff said that they knew how to report a safeguarding incident to senior staff and that there were processes in place for the reporting of safeguarding incidents in hours and out of hours.

The completion rates for safeguarding training level two, for adults and children for medical staff were worse than those of the last inspection. At the last inspection all staff had completed level two safeguarding training for vulnerable adults and children and young people and 82% of appropriate staff had completed level three safeguarding training for children and young people.

The trust set a target of 90% for completion of safeguarding training.

Levels of training for safeguarding were consistent with the safeguarding children and young people: roles and competences for health care staff, intercollegiate document.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing staff working in the medicine division is shown below:

![Safeguarding Training Completion by module](image)

The 90% target was not met for any of the safeguarding modules by medical and dental staff in the medicine division at the trust. Level 2 adults and children’s training was completed by 251 and 250 of the 294 eligible staff members, this equates to 85% of staff.

Compliance for level 3 adults was the lowest, with only 56 (51%) of the 110 eligible staff members completing the training.
Nursing staff in the medicine division exceeded the 90% completion target for both level 2 adults and children safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. The wards that we visited were visibly clean and tidy. Not all the wards had a hand wash sink at the entrance to the ward, but there was a programme of installation underway. All wards had hand gel available outside and inside the ward. Patients told us that the hospital was “really clean” and that the housekeeping staff were excellent. All the medical wards displayed the outcomes of their hand washing audits on boards outside the wards.

All the audits we saw on the medical wards were at 100% compliance. We saw personal protective equipment was available and staff used it appropriately. There was a yellow card system in place on the wards and staff could be given a yellow card by a senior member of staff if they did not follow infection control policy. If they received two yellow cards they had to complete additional training. Following a number of cases of Clostridium difficile on the wards, actions had been put in place to address these. All patients with Clostridium difficile were identified with an orange wrist band and there were orange stickers in the case notes to identify the patients with the infection. Infection control link nurses were delivering training on the wards and on the acute medical unit there had been no cases of Clostridium difficile since August.

There were boards outside the wards explaining the collaborative work that was ongoing. The results of handwashing audits were displayed and we saw that these were at 100%. On the respiratory ward there had been no incidence of meticillin resistant Staphylococcus aureus since April 2014 and no incidence of Clostridium difficile since October 2015.

The hospital had addressed the hand hygiene of patients with packs of hand wipes and information cards about when to use wipes and how to use them effectively. Patients on the acute medical unit were provided with information about infection control as a part of the information pack for the ward which they received on arrival on the ward.

Environment and equipment

The service had suitable premises and equipment. The acute medical unit was due to be redesigned to make the two wards into one.. The plan was to have 40 beds and an ambulatory
care unit. There were also plans for procedure rooms and a staff room. The work was to be completed in the next month to help to address winter pressures.

On the cardiology ward, we saw that the the rooms were well laid-out with the scrub room linked directly to the cardiac catheter laboratory. On the respiratory ward, there was a procedure room for procedures such as insertion of chest drains. These interventions were previously carried out on the ward, but this had been altered to reduce distress for patients and others on the ward.

We saw that equipment was maintained, serviced and checked as required. At the last inspection, it was unclear if resuscitation equipment was always being checked which meant that emergency equipment might not be available when needed. At this inspection, we checked three resuscitation trollies. All the trollies had the appropriate checks in place and these were documented. There was a basic daily check and a full check was carried out every week.

We saw that there was appropriate management of waste with colour coded bags. There were dirty utility rooms on the wards where clinical waste was stored until disposal. Sharps boxes were labelled correctly and were not overfilled.

Assessing and responding to patient risk

The service had effective systems in place to assess and respond to patient risk.

The sepsis 6 bundle was rolled out by the trust in April 2017 as part of the deteriorating patient collaborative. The trust also started to use the national early warning scores system to help identify the deteriorating patient and the triggers to flag for sepsis. As part of patient observations, the electronic recording system calculated the national early warning scores for each patient. The hospital had provided sepsis training for staff on the acute medical unit and 95% of appropriate staff had completed this training. There was also a sepsis ward champion on the unit and a clinical lead for sepsis who had been in post for two months. We saw that there was evidence of appropriate screening and an escalation policy was in place. There were posters on the walls and information cards for the staff about sepsis 6. The implementation and roll out of the sepsis 6 pathway was overseen by the clinical effectiveness committee.

We observed the morning handover of the acute medical unit. It was well attended and the meeting covered operational issues and feedback from a patient complaint. Other issues covered included new admissions, any patient with a deprivation of liberty safeguard, any patient at end of life or with a do not resuscitate decision, any patient who had taken an overdose who had dependents, patients who had the same name, any relatives staying on the unit and patients with additional nutritional needs. There was a proforma for the meeting which was completed by the senior nurse from the night shift.

On the acute medical unit there was a stamp for patients’ records to inform staff that the doctor had been informed about a deteriorating patient. Staff were able to see if a doctor had attended the patient in a timely manner.

During the previous inspection, we found that nursing staff had been unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint. At this inspection, we saw on the stroke rehabilitation ward, that a failsafe bundle was carried out for each patient; this was electronic and was a series of risk assessments. This included the use of bedrails and staff completed a survey about the patient which then advised on the use of bedrails. Staff said that they could override this with their clinical judgement for patients with fluctuating capacity or levels of consciousness.

There were two assessment beds on the hyperacute stroke unit where staff could closely monitor patients admitted from urgent and emergency care. The allied health professionals on the stroke unit carried a bleep so that they could see patients in a timely manner when admitted to the hospital with a stroke. One of the stroke consultants was on call for the day and could support patients admitted into urgent and emergency care who had suffered from a stroke.
Following a serious incident, the medical staff had worked with surgical staff and had adopted the World Health Organisation checklist for use in the cardiac catheter laboratory. We saw that the checklist was used for each patient and that the checklist was audited with appropriate actions put in place.

There was a blood gas analyser on the respiratory ward so that urgent test results could be obtained in a timely manner.

Patient moves per admission

Between June 2016 and May 2017, overall at the trust, 60% of individuals did not move wards during their admission, and 40% moved once or more.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of individuals not moving wards</th>
<th>% of individuals with one or more ward moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Manchester General Hospital</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Rochdale Infirmary</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Fairfield General Hospital</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Return – Bed Moves)

Nurse staffing

Although the medical wards were not always fully staffed, managers had put measures in place to reduce risks to patients.

On the stroke ward the allied health professionals helped patients to wash and dress as part of their rehabilitation and on ward 21, a ward with a significant number of patients with dementia, a pharmacy technician was responsible for the medicines rounds for oral medicines. The ward clerk had been given additional hours to answer phone calls and to deal with enquiries from patients relatives.

The hospital managers told us that they had recruited an additional 14 registered nurses and 30 additional health care assistants for the period April 2017 to March 2018. Nurse managers on the wards told us that they had new staff or that they had staff starting with induction dates. To address the gaps in staffing, some nurses had been promoted to aid retention of the staff and to address the gaps in skills and competencies. This included a number of new ward managers who were being developed into the role.

Overtime was offered to staff who wished to work extra shifts. Agency staff were used by the hospital and it was easier to get agency staff to work at night and the weekends. On one of the wards there was one trained staff at night with two trained agency staff and the manager said that there had been an increase in incidents at night. The ward manager had supported the night shift to assure themselves about patient risk. The ward was waiting for the new starters in December 2017 and would almost be fully established.

The acute medical unit had 35% registered nurse vacancies in March 2017 and, following recruitment and a skill mix, all posts were recruited to. The ward manager had been involved in overseas recruitment of nurses in Ireland and India.

The trust has reported the following planned and actual staffing figures for nursing and midwifery council registered staff working in medicine for the period December 2016 to May 2017.
<table>
<thead>
<tr>
<th>Month</th>
<th>Whole time equivalent staff in post</th>
<th>Whole time equivalent staff planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>443.72</td>
<td>532.88</td>
</tr>
<tr>
<td>January 17</td>
<td>437.43</td>
<td>530.88</td>
</tr>
<tr>
<td>February 17</td>
<td>436.90</td>
<td>531.88</td>
</tr>
<tr>
<td>March 17</td>
<td>443.09</td>
<td>532.48</td>
</tr>
<tr>
<td>April 17</td>
<td>437.23</td>
<td>533.34</td>
</tr>
<tr>
<td>May 17</td>
<td>434.07</td>
<td>544.75</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 16.9% for nursing staff in medicine;

Fairfield General Hospital: 21.2%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.3% for nursing staff in medicine;

Fairfield General Hospital: 1.2%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 4.3% for nursing staff in medicine, which is in line with the trust target of 4.6% for sickness rates.

Fairfield General Hospital: 4.9%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

In the routine provider information request the following medical wards were listed as three of the five wards across the trust with the highest bank or agency use.

- CG316 Acute Medical Unit – Royal Oldham Hospital
- CJ312 Ward E1 – North Manchester General Hospital
- CH316 Ward 21 – Fairfield General Hospital

This high use of agency and bank staff on these wards was attributed to high vacancy rates, long term sickness and absence.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

Consultants told us that although there had been an increase in medical staffing, there were still gaps in staffing.
Consultant staffing was good on the acute medical unit. There were two consultants who started at 8am and three consultants who started at 9am. There was 12 hour consultant cover on the unit. The acute medical unit was fully established for acute physician posts with funds secured for an additional two consultants and three middle grade doctors as part of the expansion to ambulatory and the additional bed capacity. There was additional consultant cover in cardiology and there was funding for additional posts.

There were 12 vacancies for echocardiogram sonographers and the hospital used an agency to support the service. The consultants could undertake basic sonography. The recruitment of sonographers is a national problem. The service would like to offer cardiac computerised tomography and were looking to recruit an additional consultant for this role.

The hospital had appointed three pharmacy assistants and had put a business case forward for additional pharmacy support. The pharmacists would be able to prescribe medicines for patients.

The trust has reported the following planned and actual staffing figures for medical and dental staff working in medicine for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>120.06</td>
<td>131.52</td>
</tr>
<tr>
<td>January</td>
<td>118.06</td>
<td>131.52</td>
</tr>
<tr>
<td>February</td>
<td>118.76</td>
<td>131.52</td>
</tr>
<tr>
<td>March</td>
<td>119.46</td>
<td>131.52</td>
</tr>
<tr>
<td>April</td>
<td>120.06</td>
<td>131.52</td>
</tr>
<tr>
<td>May</td>
<td>120.86</td>
<td>131.52</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.2% for medical and dental staff in medicine;

Fairfield General Hospital: 7.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017 the trust reported an average turnover rate of 2.1% for medical staff in medicine;

Fairfield General Hospital: 1.6%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 0.3% for medical staff in medicine which is better than the overall trust target of 4.6% for sickness rates.
Fairfield General Hospital: 0.3%
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Staffing skill mix**

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average whilst the proportion of junior (foundation year 1 and 2) staff was slightly higher.

Staffing skill mix for the 252 whole time equivalent staff working in Medicine at The Pennine Acute Hospitals NHS Trust.

![Staffing skill mix chart](image)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>25%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/05/2017 - 31/05/2017)

**Records**

Staff kept appropriate records of patients’ care and treatment and held these securely. This was an improvement from the last inspection which had found standards in record keeping required improvement and records were left unsecured on the acute medical unit and ward 21.

At this inspection, there was a mixture of electronic patient records and paper records. The nursing records were mainly electronic and included risk assessments, observations and medicines charts. We reviewed 11 paper records and we saw that they had been completed appropriately with signatures. In one set of notes one of the diagnostic test results had no name or date of birth but this was not a consistent issues. We saw that the stroke patient therapy records had been completed; these were paper based and we looked at five records that showed the plan for the patients and their progress against the plan. There were different coloured stickers for different therapists and the input was clearly signed and dated. The medical staff were currently using paper notes as they did not feel it was safe to go over to the electronic records at this time.

The trollies for storage of patient records had digital locks on them. Security of patient records was raised at the last inspection. We saw that doctors removed records when dealing with patients replaced them into the trollies at the end of each consultation.

Allied health professionals peer reviewed each others patients’ records checking that they had been completed and signed appropriately.
Medicines

The service prescribed, administered, recorded and stored medicines well. We saw that medicines including controlled drugs were stored appropriately. Fridge temperatures were checked and recorded and room temperatures were also checked and recorded. The controlled drugs cupboards were checked by the night staff every night and then by the ward manager every week. The pharmacists also checked the controlled drugs every three months. This was in line with the recorded drugs and controlled drugs policies. On the medical wards, there were electronic drugs trollies for each bay; these supported the audit of medicines in each area.

There were guidelines for the self-administration of medicines by patients and there were different levels of self-administration. We saw that medicines were stored in patient’s bedside lockers. Controlled drugs could not be self-administered by patients, but if they were brought into the hospital they were stored separately from the ward controlled drugs cabinet and recorded appropriately.

Incidents

The service managed patient safety incidents well. The hospital had recently changed its electronic incident reporting system, managers and staff said that the system was much improved and that they could record positive feedback for staff. There had been a 25% increase in incident reporting since the implementation of the new system. The medical director told us that there were less trends in the incidents reported and that they appeared to be more sporadic.

Staff in the cardiology department described four incidents that met the serious incident criteria. They told us about the incidents and the lessons learned from the incidents. We saw that changes had been made to practices including improvements of patient consent procedures following one incident. Two of the consultants had received root cause analysis training.

The hospital was meeting the timeframe for the investigation of incidents in more that 90% of cases.

The medical director produced a newsletter for medical staff about incidents and lessons learned.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Between August 2016 and July 2017, the trust reported no incidents which were classified as never events for Medicine.

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 41 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017.
The breakdown of incident types was:

- 14 slips/trips/falls meeting SI criteria (34% of total incidents)
- 11 all other categories (27% of total incidents)
- 6 sub-optimal care of the deteriorating patient meeting SI criteria
- 4 VTE meeting SI criteria
- 3 treatment delay meeting SI criteria
- 3 HCAI/Infection control incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

The service used safety monitoring results. Staff collected safety information and had used information to improve the service.

The hospital had put measures in place to reduce serious falls and had set a target to reduce falls by 20%. They were on track as they had only five serious falls since December 2016. The target was less than 12.

We saw on one ward that patients at high risk from falling were put on one to one observation by staff who wore distinctive coloured tabards and were not allowed to leave the patient unless someone could take their place. There was also ‘bay tagging’ in place on some wards to try to prevent falls; this involved a member of staff remaining on the bay at all times.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 41 new pressure ulcers, 29 falls with harm and 24 new catheter urinary tract infections between August 2016/17 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Pennine Acute Hospitals NHS Trust

Pressure ulcers were recorded for every month during the period aside from June 2017. Falls were recorded for every month during the period. C.UTIs were recorded for all months during the period except September 2016 and March 2017.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. There was an effectiveness committee at the hospital and audits of implementation of guidance and compliance with pathways were reported at this committee.

There was a clinical effectiveness facilitator at the trust who informed appropriate teams of new guidance including guidance from National Institute of Health and Care Excellence. The team then reviewed and audited the implementation of the guidance. They informed the services about their compliance with the guidance.

New guidance was also shared at governance and team meetings. We saw that the stroke unit had looked at the Royal College of Physicians guidelines for stroke and had an action plan to implement the guidelines. Each guideline was allocated to a specific member of the team and they had responsibility for the implementation of the guideline. Staff told us that guidelines were discussed at meetings.

There were evidence-based clinical pathways for each speciality in medicine which were available on line for staff.

All patients were seen and reviewed by a consultant on the acute medical unit twice a day.
The trust and the hospital were addressing falls prevention with guidance from the Royal College of Physicians.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. The local clinical commissioning group had reported significant assurance of nutritional assessment monitored through the nursing assessment and accreditation scheme. We saw that malnutrition universal screening tool charts had been completed appropriately. Fluid balance charts were paper based and were completed in the three patients that we observed.

Patients were supported in their eating and drinking by ward staff. In the stroke survey 86% of patients said that a meal was made available when requested, they also said that staff had made tea and toast available to them when they had arrived on the ward at night. On the stroke unit swallowing assessments had been completed electronically and were stored in the patients records. We saw that soft food and liquified food was provided for patients with swallowing problems.

Patients said that the food was good and there was always a menu with plenty of choice, they said that there was always fresh water available to drink and that staff would bring them a hot drink if they asked for one.

**Pain relief**

Pain scoring was part of the early warning score for each patient. We saw that patients were offered appropriate pain relief and that this was recorded in the patient record. There was a cognitive impairment assessment scale for patients with communication difficulties including dementia, stroke, learning disability and acute confusion.

**Patient outcomes**

The trust participated in national audits. The service monitored the effectiveness of care and treatment and used the findings to improve them.

**Trust Level: Elective Admissions**

![Trust Level: Elective Admissions Graph](image)

Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Clinical Haematology and General Medicine patients had a lower than expected risk of readmission for elective admissions.
- Gastroenterology patients had a higher than expected risk of readmission for elective admissions.
Between May 2016 and April 2017;

- All patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- General Medicine patients had a similar to expected risk of readmission for non-elective admissions.
- Infectious Diseases patients had a higher than expected risk of readmission for non-elective admissions.
- Cardiology patients had a lower than expected risk of readmission for non-elective admissions.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

Between May 2016 and April 2017;

- All patients at Fairfield General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Cardiology, Gastroenterology and General Medicine patients had a lower than expected risk of readmission for elective admissions.

Fairfield General Hospital: Non-Elective Admissions

Between May 2016 and April 2017;

- All patients at Fairfield General Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- General Medicine and Respiratory medicine patients had a lower than expected risk of readmission for non-elective admissions.
readmission for non-elective admissions.
- Diabetic medicine patients had a higher than expected risk of readmission for non-elective admissions.

**Sentinel Stroke National Audit Programme**

Fairfield General Hospital takes part in the quarterly Sentinel Stroke National Audit Programme. On a scale of A to E, where A is best, the trust achieved grade A in the latest audit dated December 2016 and March 2017.

Overall scores for the unit have remained consistent at grade A through all quarters, January 2016 – March 2017. Both patient centred and team centred performance has remained consistent across all domains from April 2016 – March 2017. Fluctuating only slightly from grade A to B in both team and patient physiotherapy in the latest quarter and increasing from grade B to A in patient centred Thrombolysis.

(Source: Royal College of Physicians London, SSNAP audit)
The stroke service was the sixth best stroke service in the country. There were joint assessments of patients by all appropriate allied health professionals. Patients had an individual plan with personal goal setting and outcome measures, that had been completed and updated. The speech and language therapists followed patients through their journey through stroke services at the hospital. Patients were asked to rate their own speech before and after therapy.

On the rehabilitation unit there were rooms for therapy interventions from occupational therapists and speech and language therapy, there was also a gym for physiotherapy treatment. There was a breakfast club and patients were encouraged to make their own breakfasts and we were told that the patients had cooked a Sunday lunch on the weekend prior to the inspection.

The service was developing thrombectomy surgery with surgical services at Oldham as thrombectomy surgery can significantly reduce disability for strokes involving a blood clot on the brain. There were two slots per day reserved on the surgical list. The stroke service was working at improving outcomes for patients who were taking anti-coagulants before they had their stroke and needed to continue these medicines following their stroke.

If stroke patients were admitted from other hospitals in the group, staff tried to facilitate transfers in a timely manner. They were aiming for transfers within two hours, so that patients could be admitted to the stroke unit for assessment to give a better outcome for the patient.

There were early supported discharge teams in all the local clinical commissioning group areas so that people could be discharged safely and in a timely manner to their home or other accommodation. There was a social worker on site from the local authority and the hospital had links to the other social workers in the neighbouring local authorities.

Heart Failure Audit
In-hospital Care Scores

In the 2015 Heart Failure Audit the trust’s performance in relation to in-hospital care was as follows:

- Fairfield General Hospital, North Manchester General Hospital and Royal Oldham Hospital were all worse than the England and Wales average for all of the four of the standards relating to in-hospital care.
- Rochdale Infirmary was worse than the England and Wales average for three of the four standards relating to in-hospital care.

![Heart Failure Audit Graph](image-url)
In hospital care – England and Wales averages

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology inpatient</td>
<td>48.1%</td>
</tr>
<tr>
<td>Input from consultant cardiologist</td>
<td>58.6%</td>
</tr>
<tr>
<td>Input from specialist</td>
<td>79.9%</td>
</tr>
<tr>
<td>Received echo</td>
<td>91.7%</td>
</tr>
</tbody>
</table>

Discharge Scores

In the 2015 Heart Failure Audit the trust’s performance in relation to discharge was as follows:

- Fairfield General Hospital, Rochdale Infirmary and North Manchester General Hospital were all worse than the England and Wales average for six of the seven standards relating to discharge, but better for received discharge planning.
- Royal Oldham Hospital was better than the England and Wales average for six of the seven standards relating to discharge, but worse for referral to cardiology follow up.

(Required figures above)

Discharge scores – England and Wales averages

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI on discharge</td>
<td>72.2%</td>
</tr>
<tr>
<td>ACEI/ARB on discharge</td>
<td>83.6%</td>
</tr>
<tr>
<td>Beta blocker on discharge</td>
<td>85.7%</td>
</tr>
<tr>
<td>Received discharge planning</td>
<td>87%</td>
</tr>
<tr>
<td>Referral to cardiology follow-up</td>
<td>52.2%</td>
</tr>
<tr>
<td>Referral to HF liaison service</td>
<td>57.9%</td>
</tr>
<tr>
<td>Referral to HF liaison service (LSVD only)</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

(SOURCE: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)
National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit, measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified that there were 44 inpatients with diabetes at Fairfield General Hospital, 76.7% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 1.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to the audit program by hospital site (as opposed to trust).

Between April 2014 and March 2015, 13.6% of non-ST-elevation myocardial infarction (this is a type of heart attack) patients were admitted to a cardiac unit or ward at Fairfield General Hospital and 88.9% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%.

The proportion of non-ST-elevation myocardial infarction patients who were referred for or had angiography at Fairfield General Hospital was 93.9% compared to an England average of 79%.

<table>
<thead>
<tr>
<th></th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
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<tr>
<td>Fairfield General Hospital</td>
<td>433</td>
<td>433</td>
<td>246 (246)</td>
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<tr>
<td></td>
<td>88.9%</td>
<td>13.6%</td>
<td>93.9% (No data)</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>235</td>
<td>235</td>
<td>151 (151)</td>
</tr>
<tr>
<td></td>
<td>97%</td>
<td>25.1%</td>
<td>100% (No data)</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>385</td>
<td>385</td>
<td>245 (245)</td>
</tr>
<tr>
<td></td>
<td>96.6%</td>
<td>8.6%</td>
<td>84.9% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
</tr>
<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 77%, which was lower than the audit minimum standard of 90%. The 2015 figure was 92%.

The proportion of patients with histologically confirmed non-small cell lung cancer receiving surgery was 25.5%, this is not significantly different from the national level. The 2015 figure was 27%.

The proportion of fit patients with advanced non-small cell lung cancer receiving chemotherapy was 57.4%, this is significantly lower than the national level. The 2015 figure was 51%.

The proportion of patients with small cellt cancer receiving chemotherapy was 64.9%, this is significantly lower than the national level. The 2015 figure was 70%.
The one year relative survival rate for the trust in 2016 is 34.1%, this is below the national aggregate.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust didn’t take part in the 2015 Audit of Inpatient Falls.

(Source: Royal College of Physicians)

Competent staff

There were systems in place to make sure staff were competent for their roles. Although trust data showed 52% of staff had received an appraisal, all the staff we spoke with had completed an appraisal. They said that the process was useful for their development and was not just a tick box exercise. Staff also had one to one meetings every four to six weeks and received regular clinical supervision.

There was a bay on the acute medical unit called the “synergy bay” that was run by nursing students (year one to three) and supervised by senior nursing staff. It was used to support nursing staff to develop their clinical competencies and to develop their leadership skills. Medical staff would address any issues through the students. The students had a learning log and individual objectives for competencies that they needed to achieve whilst working in the area.

Staff said that there was good training and support for all staff on the stroke unit with the allied health professionals training some of the nursing staff if appropriate. There were multidisciplinary team meetings where case studies were used to look at best practice and lessons learned. These were weekly for one hour and open to all staff.

A senior nurse on the cardiology ward said that there were monthly training sessions on the ward and that there had been a cardiac study day for staff. The nurse had also attended an electrocardiogram course. Another member of staff said that they had completed a post-graduate module in arrhythmia management. A newly qualified member of staff on the acute medical unit told us that they were well supported and had received all the training that they requested. They had attended a number of study days to support their training. New nursing members of staff on the cardiology unit were allocated a mentor who was not the ward manager.

There was a part time practice based educator on the respiratory ward. They provided training in areas such as non-invasive ventilation and chest drain care. They had also developed a newly qualified training programme and they checked the competencies of the staff. The trust had recently organised a tracheostomy care day for appropriate staff.

The hospital provided training to staff who might have to attend a coroners court. This included doctors and nurses.

Appraisal rates

Between June 2016 and May 2017, 55% of staff working within medicine at the trust had received an appraisal compared to a trust target of 90%.

The 55% appraisal rate applies to nursing and midwifery council registered staff, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust provided appraisal rates of 100% for medical and dental staff across all areas of the organisation.

At Fairfield General Hospital 52% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working

Staff worked together as a team to benefit patients. All staff described effective working between consultants, nurses and allied health professional staff. There was excellent multidisciplinary team working in stroke service at the hospital. The service included input from allied health professionals including physiotherapists, occupational therapists, speech and language therapists and orthoptists. There was also a psychology service. There were also good links to radiology services, urgent and emergency care and vascular surgery services at Oldham.

Staff on the respiratory ward said that they had good support from the community respiratory team and that they worked well together to support patients following discharge and if patients needed to be readmitted to hospital.

Seven-day services

Seven day service provision was not available in all areas. There was a seven day rota for the stroke service at the hospital for physiotherapists and occupational therapists and new patients and patients about to be discharged were always seen. The was not always a seven day service as there were not enough speech and language therapists to provide this. The speech and language therapists tried to provide a six day service, but this was voluntary and was dependent on staff numbers.

There was not a seven day service for cardiology patients as there was no consultant ward round at weekend, though there was a consultant cardiologist available on call. The cardiologists participated in a number of on call rotas across the health economy and so there were not enough of them to provide a seven day service at Fairfield General Hospital.

Health promotion

Staff and patients were offered the influenza vaccines when they were at the hospital. The director of nursing toured the wards to promote and deliver the vaccinations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated an understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. This was an improvement from the previous inspection, where we found staff were not always following trust policies and procedures in relation to assessing patients for capacity and in the completion of capacity assessments.

Training for the Mental Capacity Act (2005) and Deprivation of Liberty safeguards was part of the adult safeguarding training.

We saw in two patient records that the “do not recuscitate” documentation was up to date.

The nurses on the acute medical unit told us that there was a formal document completed for patients who lacked capacity. They explained the processes about how to complete the documentation and described best interest meetings that had been held for patients. There was guidance on the hospital intranet on best interest decisions and the Mental Capacity Act including a summary of actions. There was continual reassessment of Deprivation of Liberty safeguards for patients as they moved through the hospital.

There were procedure specific consent forms for cardiac catheter procedures. We saw that if the nurse had consented patients, that this was reaffirmed on the day of treatment. If consent had been taken by a different doctor who was not completing the procedure, then this was reaffirmed on the day of treatment.

There were consent forms for the self-administration of medicines.
Mental Capacity Act and Deprivation of Liberty training completion

Data for this metric was not provided.
(Source: Trust Routine Provider Information Return (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

We observed that staff were caring and compassionate to patients and that they respected their privacy and dignity at all times.

Patients we spoke with said that staff never moved them without asking them first. The stroke service did its own patient survey and changes were made to services following patient feedback. All the feedback we received from patients was positive, although they all said that staff were really busy. Feedback included comments such as the staff are ‘amazing’ and ‘they have all been brilliant.’

Patients on the stroke unit said that there was a good atmosphere and the staff including the housekeeping staff always chatted to the patients. The hospital had a volunteer who worked for three days a week doing face to face feedback with patients.

A patient we spoke with on the cardiology ward said that staff were very busy, but that they did not think that this had impacted on their care. They described feeling anxious overnight, but that the staff had been attentive and caring.

The activity co-ordinators on ward 21 had started a clothes store for patients who had few clothes. Clothes were donated to the ward and they had an arrangement with the laundry services to wash the clothes.

Friends and Family test performance

Between August 2016 and July 2017 the Friends and Family Test response rate for Medicine at the trust was 22% which was slightly worse than the England average of 25%.

A breakdown of percentage recommended by site and ward is shown below:
Emotional support

Staff provided emotional support to patients.

There was a psychology service for patients following a stroke which continued into the community; there was one psychologist supported by a nurse.

A patient who was admitted from urgent and emergency care had suffered a bereavement which had led to their admittance to the hospital. The patient was treated in a side room and support was given from the bereavement team, the patient had written to the ward to thank them for their support at a difficult time in their life.

There were link nurses on the acute medical unit to support patients and their relatives. A health care assistant who had previously worked at a hospice provided emotional support for patients and their relatives on the acute medical unit.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

In the patient survey from the stroke unit, 95% of the patients said that they had been involved in decisions about their care; and 71% of patients said that staff explained to their relatives what had happened and what was going to happen to them. A number of comments were that patients were alone when admitted and some patients said that they had no friends or relatives. In the patient survey, 95% of patients’ relatives on the stroke unit said that they were allowed to visit the ward when they wanted to at a time convenient to them. Relatives were allowed to stay on the stroke unit. Patients on the stroke unit said that the focus was about the family and not just about the patients and that families were invited to all meetings that involved the patients and their ongoing care. On the stroke unit, we were told about a patient’s relative who lived a long way from the unit and was not very mobile. The hospital paid for a taxi so that the patient could visit their relative during the duration of their stay.

On the acute medical unit, staff discovered that a patient had a significant wedding anniversary; the patient had cognitive impairment and was unaware of the event. The staff got a cake for the patient and their relative and staff sang “congratulations”. The family of the patient, who lived abroad, rang the ward to thank them for their gesture.
On ward 21, activities were provided by activity co-ordinators and some of these activities involved family members. Staff had taken one of the patients on ward 21 to his son’s wedding and had permitted relatives to bring dogs onto the ward.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Clinical services were clinically led and clinically driven by the staff to improve patient outcomes.

Redesign of the stroke service had started several years ago when the service was located across different locations of the trust. All the stroke services (except surgery) were now located at Fairfield and staff had moved from the other sites to support the service. There was a hyperacute stroke unit with nine beds, an acute stroke unit with 16 beds and two stroke rehabilitation wards with 20 beds each which was the stroke service for the trust. The stroke unit had a 24 hour service for patients with transient ischaemic attacks and were working with commissioners to develop this into a seven day service.

There were two cardiology wards at the hospital; one was used for cardiology patients and the other was for patients with cardiology problems and other co-morbidities or issues such as infection. There was no on-site presence for patients with acute kidney disease. There was a service level agreement with a neighbouring trust for consultant cover, but the consultants and the medical director said that they did not always know if the consultant had visited the hospital and which patients had been seen.

The acute medical unit had 30 beds which was due to increase to 40; building work was due to begin to make two wards into one. This also included the ambulatory care unit. The ambulatory care unit was part of the acute medical unit and there was seating available for patients. There were criteria for the unit and some clinics were also delivered from the unit. The hospital had recruited additional medical cover for the unit so that it could open for 12 hours every day.

On the acute medical unit there was a supernumery nurse for every shift to liaise with discharge planners to co-ordinate discharge. The unit had its own porter, so that patients were moved in a timely manner.

Patients arriving on the acute medical unit received a welcome pack of information including information on falls and infection prevention, hand hygiene, medicines, blood tests, reducing the risk of blood clots, emotional support and discharge. The pack also contained a communication diary for patients, so that they could write down any information they wanted to share with health professionals. The information pack was available in other languages if required.

Average length of stay

Trust Level: Elective Average Length of Stay

![Average length of stay chart]

Between June 2016 and May 2017;
The average length of stay for all elective patients at the trust was 5.1 days, which is higher than the England average of 4.2 days.

Average length of stay for Gastroenterology and General Medicine elective patients is lower than the England average.

Average length of stay for Clinical Haematology elective patients is higher than the England average.

Trust Level: Non-Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at the trust was 5.0 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine and Infectious diseases non-elective patients is lower than the England average.
- Average length of stay for Cardiology non-elective patients is higher than the England average.

Fairfield General Hospital: Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all elective patients at Fairfield General Hospital was 2.9 days, which is lower than the England average of 4.2 days.
- Average length of stay for Cardiology and General Medicine elective patients is higher than the England average.
- Average length of stay for Respiratory medicine elective patients is lower than the England average.
Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at Fairfield General Hospital was 5.6 days, which is lower than the England average of 6.6 days.
- Average length of stay for General Medicine, Geriatric medicine and Respiratory medicine non-elective patients is lower than the England average.

The Clinical Admissions Unit is a six bed assessment unit and ambulatory care centre providing clinical management to adults with acute in-hospital needs for assessment, observation, and short term in-patient treatment.

Ambulatory conditions include pleural embolism, deep vein thrombosis, chest pain, atrial fibrillation, acute kidney injury, urinary tract infection, sepsis, pneumonia, respiratory tract infections, ascites and drainage, anaemia, acute headache, seizures and diagnostic work-up and follow-up treatment for ward attenders. Plus (in hours) same day magnetic resonance imaging computed tomography scans, access to beds on the programmed investigations unit, and Oasis dementia care unit.

The Oasis Unit was a six bed facility for the assessment, diagnosis and treatment of patients with dementia and an acute medical in-hospital need. Patients can be referred from the UCC, CAU, or direct GP referral.

(Source: Hospital Episode Statistics, RPIR – Sites Acute Tab)

Meeting people’s individual needs

The service took account of patients’ individual needs. All the wards were dementia friendly with appropriate signage on the doors. Bathrooms had been designed specifically for use by patients with dementia and cognitive impairment. The hospital had rolled out “end pj paralysis” an initiative from NHS Improvement. Appropriate patients were encouraged to wear their own clothes during the day in hospital. The initiative promotes quicker recovery, helps patients to maintain a normal routine and helps them to return home sooner. We saw that this had been implemented and staff said that it worked.

There were activity co-ordinators for the patients on ward 21 who had dementia or cognitive impairment. We saw that there was a timetable of activities for mornings and afternoons seven days a week. The co-ordinators said that these were flexible to meet patients needs. During the inspection we saw that patients were enjoying an afternoon tea and discussing newspaper articles. The co-ordinators worked with the patients to produce an activity diary so they could record the activities in which they had participated. Managers told us that since the activity programme had started that there had been less falls on the ward at night and a reduction in staff needed for enhanced observations. The activity co-ordinators completed “what matters to you” boards for each patient; the initiative had been successful and rolled out onto other wards.

On the acute medical unit, patients meeting certain criteria were assessed using a frailty tool. These patients were over 75, with cognitive impairment and often from nursing homes. They were assessed daily and the objective was to discharge them safely within three days. They
received physiotherapy and occupational therapy support and could be “discharged to assess”. This meant that assessment could be followed up in the patients place of residence following discharge.

The stroke service supported patients with asphasia and there were communication passports that had been developed with the patients. A note could be put onto the hospital appointment system so that patients were informed of their next appointment by the most appropriate communication method agreed with the patient. The hospital had developed a stroke garden that could be used for patients and their relatives. There were raised beds and it was hoped that therapy sessions could be delivered there in appropriate weather conditions. On the stroke rehabilitation unit nurses provided activities for patients in the afternoons to support their rehabilitation, these included games and hand massage. Patients were encouraged to bring in their own clothes to wear in the daytime.

Many patients on the respiratory ward were very poorly and the ward provided support for relatives so they could stay at the hospital. There was a room for relatives with camp beds if relatives wanted to stay overnight. Food and refreshments were provided and also toiletries for relatives. Games and puzzles were available for children and the nurse said that it would be redecorated in the near future.

We saw on the ward that the ward was able to meet the needs of bariatric patients who were receiving treatment. There was appropriate equipment to meet their needs and beds could be removed from the bay to create more space.

There was an ethnic health team at the hospital who could provide information in other languages, we saw that the welcome pack for the acute medical unit was available in other languages. During the inspection we saw that there was an interpreter on one of the wards.

There was a learning disability team at the hospital to provide support for patients with a learning disability and the nursing assessment documentation included an alert for these patients on the hospital computer system. Relatives of patients were encouraged to attend and patients were allocated side rooms if possible with camp beds for relatives who wished to stay overnight.

**Access and flow**

The service had taken steps to improve access and flow. The acute medical unit was aiming to increase the length of stay on the unit for patients to reduce multiple bed moves to other wards. The aim of this was to “discharge to assess” for appropriate patients. The department had also introduced the frailty tool to discharge patients who met certain criteria to be discharged with appropriate support in a timely manner.

Patients moved through the hospital from the urgent and emergency care department in a timely manner for assessment. If the urgent and emergency care department was busy, consultants from the acute medical unit supported colleagues to help to move people through the hospital.

Medical outliers were usually placed on ward two; there was a duty consultant of the week who had no out patient clinics who undertook ward rounds, supported colleagues in their work and saw the medical outliers.

There was an integrated discharge team manager who was responsible for discharge and discharge planning. They were employed by adult social care in the local authority, but were line managed by the hospital. They said that this was positive and they felt part of the hospital team which helped in the discharge process. Some of the issues were the number of local authorities in the area and they wanted to develop a trusted assessor model so that any hospital social worker could carry out assessments for any local authority and that this would give a consistent approach to discharge.

Both the social worker and the medical staff said that there was a need for more community beds and that the choice of care home could delay discharge for medically optimised patients. They were looking at “discharge to assess” so that patients could be assessed in their own home or
place of residence and the assessment was more realistic for patient need. This was particularly applicable for patients with continuing health care needs and those who required elderly mental health placements in adult social care.

On ward 21 which had a high proportion of patients living with dementia. There were daily multidisciplinary board rounds. These were attended by the integrated discharge team due to the complexity of some of the discharges from the ward. There were daily board rounds across the medical directorate.

Due to the lack of a seven day service in cardiology, patients could not be discharged at a weekend though investigations were carried out at weekend. There were daily ward rounds Monday to Friday. The cardiology consultants were trained in basic echocardiography. This helped doctors to assess and treat patients in a timely manner.

Referral to treatment (percentage within 18 weeks) - admitted performance

Between August 2016 and July 2017 the trust’s referral to treatment time for admitted pathways for medicine has remained fairly consistent and has been in line with or better than the England average for 10 of the 12 months in the period (September 2016 and February 2017 slightly below the England average).

As of July 2017 98% of patients were treated within 18 weeks compared to the England average of 90%.

![Graph showing referral to treatment rates for Medicine](image)

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Medicine broken down by specialty is below. Of these, four of the specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.2%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and lessons learnt were shared with all staff.

Senior managers told us that that complaints were discussed every week and a decision was made if the complaint needed to be escalated for further investigation. They told us that the
response times for complaints had improved from 24\% in May 2017 to 83\% in September 2017. This meant that more complaints were being addressed by the hospital in the timescales laid out in the complaints policy.

Staff said that complaints were discussed at team meetings and if appropriate at the safety huddles.

**Summary of complaints**

Between June 2016 and May 2017 there had been 166 complaints about Medicine (20.4\% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 52 complaints still open and yet to be completed.

There were 39 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 23\%.

Fairfield General Hospital: There were 51 complaints (30.7\%)

There was one complaint relating to all sites.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

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**Is the service well-led?**

**Leadership**

There were three care organisations in the trust and Fairfield General Hospital, along with the hospital at Rochdale, formed one of the care organisations. Each care organisation had a director based leadership team comprising of a managing director who was supported by a medical director and a director of nursing. Under this structure was the division of integrated care which had a divisional managing director, a divisional director of nursing and a divisional clinical director.

Staff we spoke with said that there had been an improvement in management since January 2017 and that managers were now more visible and more approachable. Senior managers, including the medical director, did walk rounds of the wards every other week and monthly walk rounds at night.

The director of nursing spent time on the wards to discover what the issues were for the staff. Staff acknowledged that it was a good way to communicate with them. Patients commented that they had seen senior staff on the wards.

The medical director was responsible for about 75 consultants across the hospital with support from experienced clinical directors. Job planning was taking place and there was appropriate continuing professional development and study leave. The medical director had blurred the boundaries between the medical and surgical directorates; this had been successful and there was shared learning between the directorates. An example of this was the implementation of the World Health Organisation checklist in the cardiac catheter laboratory.

There had been a nine month leadership programme for ward managers. A senior nurse said that she had completed the programme which had been useful in her development. There had also been leadership programmes for senior staff.

Allied health professionals did not always feel that they were represented in the organisation. They had no representation at senior management level and said that services were developed without taking into account their skills and competencies. They said that often their input into service development was only considered after business cases had been approved meaning that funding was not in place to fund the appropriate allied health professional contribution to the service.
Vision and strategy

There was a vision and strategy for the division which included Fairfield and Rochdale hospitals. This focused on patient safety, the development of the workforce, the development of pathways outside the hospital environment and continuing to build on the current successes. Staff and managers told us that the focus of the hospital had changed from target focused services to patient centred services.

The strategy had been developed through engagement sessions with staff. There had been three separate days of staff engagement and 1000 voice events. Staff we spoke with were aware of the vision and strategy for the division.

Culture

Managers promoted a positive culture that supported patient care. The hospital had implemented the nursing assessment accreditation system. This covered a number of areas including nutrition, tissue viability, falls, medicines, care plans, patient experience and mandatory training. Wards were inspected and graded to red, amber or green. Action plans were put in place as appropriate.

There were processes in place for the application of the duty of candour. We saw that in the investigation of incidents that the duty of candour had been applied appropriately.

The acute medical unit had ward pioneers. These were link nurses who worked with staff on the ward to improve morale through peer support. The link nurses had received coaching training and had held events on the ward to encourage staff to talk about any issues that they had. One of the outcomes of this was that there was going to be a staff room on the ward once the renovation work on the ward had been completed. One of the ward pioneers had been nominated for a staff award. They told us that when the project was started as staff morale was really low, but has improved mainly due to the increased staffing on the ward and that staff retention had improved.

There was an occupational health service for staff that included psychological support if necessary. The service was in house and staff could self refer or be referred by their manager. Waiting times for the service were 24 hours for urgent referrals.

There was a divisional equality and diversity lead and one for the hospital to promote equality and diversity issues. Managers said that there was a wide diversity of staff across the professions and grades of the hospital.

Governance

There was clear accountability and objectives for the directorate that were set by the director team and the board.

Under the director leadership structure was the site management structure. The general and specialist medicine directorate had a directorate manager, three clinical directors for cardiology, stroke and general medicine and an assistant director of nursing. At all levels of management there were clinicians to support the strategic and operational delivery of services.

The management structure had been in place since January 2017 and there had been an improvement in safety performance, staffing including medical staffing and the standardised hospital mortality rates since then. Staff, including consultants said that things had improved since the new management structure but that there was still work to do.

There was a quality dashboard for the hospital which included a number of indicators and targets for safe and responsive care. The dashboard showed previous and current performance and indicated trends of the performance with colour coding.

The trust had introduced the nursing assessment and accreditation system for the wards to improve safety and quality. Wards were visited and assessed and rated red, amber and green with action plans. Ward managers said that this had improved patient safety on the wards. Staff told us that quality improvement was an agenda item at each staff meeting.
Consultants told us that there were plans to review the governance for the acute medical unit and urgent and emergency care together and that a medical governance lead had been appointed by the hospital. The medical director had appointed a sepsis lead who had been in post for two months. They were leading on the roll out of the sepsis six pathway. The hospital had also appointed an anti-microbial pharmacist who was waiting to start work at the trust.

On the cardiology unit there were weekly education/training meetings with shared learning. Significant events and complaints were also discussed at these meetings. Staff on the acute medical unit said that they had feedback from incidents and complaints at their staff meetings. These were also shared at divisional meetings. There was a monthly stroke improvement meeting and a monthly sentinel stroke national audit programme to improve the audit performance.

The trust had a service level agreement with a nearby trust to provide a service for patients with acute kidney disease. The sla was not being monitored and clarity was needed about the service provision.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them. This had improved since the last inspection when some risks on the risk register had been there since 2011 and it was unclear if all risks were managed in an effective and timely way to lower the risk.

At this inspection, there was a risk register for medical services at the hospital and we saw that risks were recorded with controls and assurances in place.

The cardiology consultants were concerned about the impact on their service from the transfer of North Manchester General Hospital to a neighbouring trust. They said that they needed clarity about the future of the service and that communication about this with the trust had been poor. They said it was difficult to develop their current service until they had more information.

The acute medical unit had prepared for a possible influenza epidemic with stocks of appropriate medicines and appropriate personal protective equipment.

During the inspection there was a power cut on ward 21. We saw that the incident was being managed and that patients were safe.

The senior staff including the medical director said that there were issues with the Deanery who are responsible for the training of doctors. They said that communication was poor and often they were unaware who was coming to the hospital until the doctors actually arrived.

**Information management**

There was a monthly quality report for Bury and Rochdale which included data from national and local audits, friends and family information, staffing levels, infection control issues and never events. The report showed the target, progress in the year and trends in performance.

The stroke service employed two data collection staff to deal with audit data and to support the service. Staff received emails about service data directly from the staff to inform them of issues in the service.

Staff described the information technology systems at the hospital as awful, it was slow and staff could loose connectivity on the wards when entering patient information.
Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.

There was a dashboard for staff engagement and a staff survey was completed every three months.

A patient who had suffered from a stroke had co chaired the working group for the redesign of the stroke service. Patient groups were also involved in the development of the communication passport for stroke patients. The stroke service worked with the stroke association to support patients. The staff were organising a world stroke day with a non speaking choir and poetry readings from somebody who had suffered from a stroke. The stroke unit had fundraising events and received donations from families to improve services for patients.

On one of the wards, nurses had visited a local school to talk about the role of nurses as it was national nurses day. The children produced a picture which was on display on the ward.

On ward 21 the activities co-ordinators had raised money so that patients could have an activities garden.

Learning, continuous improvement and innovation

The service demonstrated a commitment to improving services by learning from when things went well and when they went wrong.

The hospital had appointed a mortality lead who had administration support. The hospital were following the guidance from the Care Quality Commission learning from deaths. The frequency of mortality meetings had improved and there was now a meeting every month instead of every two months. Previously each speciality was discussed in turn, but cases were now discussed as they arose. The structure of the meetings had changed and there were joint meetings with urgent and emergency care with a focus on patient care in the first 24 hours. Cardiology, medicine and stroke shared minutes for more joined up learning as patients were shared across the specialities. There was also sharing of information about patients' pre critical care.

Greater numbers of deceased patients care was reviewed as part of the mortality review process and more than 40% of all deaths had been reviewed. Where there was evidence of preventability; this was identified and shared at morbidity and mortality meetings. Learning was identified with actions to be taken identified and completed. There were themed mortality reviews in conditions with Dr Foster alerts and mortality was a standing agenda item at junior doctors induction in August and at each rotation of junior doctors. Lessons learned from mortality reviews were shared across sites as was inquest findings from other sites.

There had been a multidisciplinary review of mortality and morbidity which included representation from senior allied health professionals, junior doctors, assistant directors, consultants, a general practitioner with links into community services and families via the bereavement nurse.

There was facilitated teaching in forums, for example mortality matters in foundation teaching by the mortality lead. The end of life team held teaching sessions for medical staff at the hospital. There were also teaching sessions by the coroner and a presentation from a family regarding resuscitation decisions and discussions.

There was a mortality oversight group with representation from doctors, nurses, junior doctors, pharmacy, governance, audit, end of life care team, a GP mortality lead, the quality improvement team, data team, clinical coding, the bereavement nurse and hospital management. There had been learning and input from the learning disabilities liaison nurse regarding learning from deaths in patients with learning disabilities. The hospital standardised mortality ratio is the ratio of the observed to expected deaths. The rate had steadily declined over the last year and was 91.8 in May 2017. The hospital had set a target of 100.
Surgery

Facts and data about this service

The trust has 135 day case and 994 inpatient beds (across all services).

Fairfield General Hospital provides elective day-case and inpatient services for ENT. This is a central service for the trust and provides emergency cover.

It also provides orthopaedic and general surgery.

Day-case services are provided for gynaecology, dental, urology, vascular and pain specialities.

There were 5,744 day case surgical admissions, 1,633 elective surgical admissions and 880 non-elective surgery admissions at this hospital between July 2016 and June 2017.

(Source: HES data)

The trust had 54,841 surgical admissions between June 2016 and May 2017. Emergency admissions accounted 15,857 (28.9%), 30,265 (55.2%) were day case, and the remaining 8,719 (15.9%) were elective.

(Source: CQC Insight)

Is the service safe?

Mandatory training

The trust set a target of 90% for completion of mandatory training.

Breakdowns of compliance for mandatory courses as of June 2017 for medical/dental and nursing/midwifery staff in the Surgery & Anaesthesia Division are shown below:

Medical and dental staff in the Surgery & Anaesthesia division met the 90% target for mandatory training compliance for two modules only (advanced paediatric life support (100%) and advanced life support (91%)).

Basic life support training had the lowest compliance levels with only 59% of eligible medical and dental staff having been trained.
Nursing staff in the Surgery and Anaesthesia division met the 90% target for mandatory training compliance in four modules, achieving 100% compliance in three (advanced life support, paediatric immediate life support and moving and handling (non-patients))

Immediate life support training had the lowest compliance levels with only 31% of eligible nursing staff having been trained.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were required to complete a programme of mandatory training. This was a combination of face to face training and electronic learning.

Staff in theatre had not received advanced life support training as recommended in national guidance. Nursing staff we spoke with had completed basic life support training, which was appropriate for their role.

Staff were encouraged to complete training when staffing permitted. There was also a smart phone application that could be accessed when not in the hospital. If completed remotely staff could request the time off in lieu. We were told that staffing numbers meant it was not always possible to complete training promptly.

Following the inspection we received the current compliance rates for mandatory training.

- Equality and Human Rights 95%
- Fire Awareness 91%
- Moving and Handling 93%
- Prevent 89%
- VTE 89%
- Induction 94%
- Local Induction 79%
- Basic Life Support 86%
- Basic Paediatric Life Support 85%
Major incident training completion rates

Data for this metric was not provided.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The service planned for emergencies and staff understood their roles if one should happen.
There was a site – specific trust major incident plan
We spoke to staff that had supported colleagues at another hospital in the trust during a major incident earlier this year.

Safeguarding

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses as of June 2017 for medical/dental and nursing/midwifery staff working in the division of Surgery and Anaesthesia is shown below:

![Safeguarding training completion by module (medical & dental staff)](chart.png)

The 90% target was only met for one of the safeguarding modules (level 2 adults) by medical and dental staff in the Surgery & Anaesthesia division at the trust. The target for level 2 children’s training compliance was almost achieved with 87.4% compliance which equated to 311 of the 356 eligible staff members completing the training.

Compliance for level 3 adults was the lowest, with only 161 of the 210 eligible staff members completing the training.
Nursing staff in the Surgery & Anaesthesia division exceeded the 90% completion target for both level 2 adults and children’s safeguarding modules. However the target for level 3 safeguarding wasn’t met for either the adults or children’s modules.

(Source: Trust Provider Information Request P18)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had safeguarding policies and procedures in place and there was a safeguarding lead that could provide guidance and support to staff in all areas.

Staff we spoke with understood who to refer a concern to and notice boards displayed contact details of safeguarding or specialist leads.

There was an electronic system that ‘flagged’ any patients that may be considered to be vulnerable.

Following the inspection we received the current compliance for safeguarding level two (children and adults) training which was 97%. The surgical services we inspected cared for adults only, therefore; there was no requirement for level three safeguarding children’s training.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All areas we visited were visibly clean. Staff followed arms ‘bare below the elbows’ guidance and washed hands prior to patient care and treatment.

Hand washing instructions were displayed above sinks with wall-mounted soap dispensers. Personal protective equipment (PPE) including disposable aprons and gloves were readily available. Sharps bins were available in all areas.

Staff received training in hand hygiene (compliance 95%) infection prevention (compliance 90%) and Aseptic Non Touch Technique (ANTT) (compliance 83%) as part of their mandatory training.

Systems were in place for the inspection and cleaning of theatre ventilation systems. These took place annually. Fans were cleaned, disinfected and airflow systems calibrated.

In theatres, display boards were made of a felt material; this meant they were difficult to keep clean.
In the wards, privacy curtains in the bays were not dated. Staff told us that if curtains were soiled they would be changed; otherwise they were not aware of when routine changes took place.

There were no surgical site infections (SSI) audits trustwide. The trust reported that between October 2016 and June 2017, there were two infections following knee replacements and two infections following hip replacements. A surgical site surveillance nurse had been recruited to monitor infections. This meant there would be surveillance for orthopaedics (hips and knees) full-time. The trust was also working with the vascular teams to undertake vascular SSI surveillance starting in January 2018.

**Environment and equipment**

At the time of inspection, the theatre walls were damaged and it was not clear when proposed refurbishment would take place. Following the inspection, we were told that refurbishment work was completed in by 20 December 2017.

This was identified in the theatre risk register with some control measures in place. However, budget constraints were affecting the repairs.

The sluice rooms where cleaning fluids were stored were left unlocked in most areas. This meant patients could access these rooms and their contents.

There were mobile computers that were accessed by all staff to record patient care and treatment. It was not always clear from the maintenance records when they were last checked. Two of these computer stations had power cables that had exposed wires; this was addressed on site and the stations removed from patient areas.

Most storage areas were locked with a keypad entrance. Patient monitoring equipment included stickers to show that electrical tests had been carried out within 12 months and weighing scales had been calibrated.

Resuscitation trolleys had a cursory check daily with a full check weekly when the coded plastic tags were broken. Ward managers checked weekly that all necessary checks had been carried out each day. Emergency equipment was checked daily and portable oxygen cylinders were secured appropriately. Sample checks of sundry items were generally in date; however eight size 12 suction catheters had expired July 2017 on one ward. This was addressed on-site and the items disposed of.

**Assessing and responding to patient risk**

The World Health Organisation (WHO) Checklist had been re-launched in August 2017. Between April 2016 and June 2017, the service reported between 97% and 100% compliance with the completion of the WHO Checklist.

However, the WHO Checklist five steps to safer surgery was not applied consistently as staff did not always verbalise checks. The trust policy for checking of swabs, sharps and instruments, ratified in January 2016, for theatres included that a verbal acknowledgement should be received from the operating surgeon in order to prevent any misunderstanding at the final count. It was observed, however; that staff were not consistently verbally checking as per policy and as per the five steps to safer surgery guidance. In May 2017 a trustwide audit of the five steps to surgery (included paediatrics) showed that there was 95% compliance with ‘sign in’, 76% with ‘time out’ and 85% with ‘sign out’.

Following the inspection we were told that the trust policy for “Correct patient, procedure and site surgery” was to be reviewed to ensure the policy was clear and understood by all staff.

Risk assessments were completed on admission for surgical patients as part of their care bundle. These included venous thrombo embolisms (VTE), Malnutrition Universal Screening Tool (MUST) and risk of falls.
The hospital had introduced an electronic system for monitoring vital signs of patients. Electronic boards recorded the Early Warning Scores (EWS) of patients. This identified patients that were at risk of deteriorating. It was colour-coded and visible to staff to highlight any patient concerns. We observed staff responding appropriately to increases in the patient scores. Staff told us that there were plans to include that if a patient had a score of five or more this would automatically alert a medical professional to attend to review the patient.

Safety huddles took place twice daily on the day case ward, with safety huddles included in staff handovers on other wards. We observed a ward handover: each member of staff had a printed sheet with a list of all patients on the ward. This included, bed number, name, age, consultant, reason for admission as well as any other condition and current health status. Details of specific concerns were highlighted such as patients at risk of falls, safeguarding or infection control risks. The safety huddle also included reminders for staff to check named guidance or changes in policies.

Following the ward handover, the ward managers had a one to one handover while other staff received a bedside handover. We were told that these were to introduce staff to patients and check all documentation was completed, however; this found that this did not always happen and conversations could be overheard by others.

Following the inspection we were told that 87% of staff have received training in sepsis six. (Sepsis is caused when the body's immune system overreacts to infection. The sepsis six is the name given to a bundle of investigations and treatments to care for patients with a diagnosis of sepsis to help improve the outcome).

**Nurse staffing**

The trust has reported the following planned and actual staffing figures for nursing and midwifery council registered staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Surgical services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE in post</td>
</tr>
<tr>
<td>December 16</td>
<td>602.14</td>
</tr>
<tr>
<td>January 17</td>
<td>602.18</td>
</tr>
<tr>
<td>February 17</td>
<td>609.35</td>
</tr>
<tr>
<td>March 17</td>
<td>609.95</td>
</tr>
<tr>
<td>April 17</td>
<td>601.75</td>
</tr>
<tr>
<td>May 17</td>
<td>603.93</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Fairfield General Hospital**

The trust has reported the following safe staffing figures for nursing and midwifery council registered and unregistered staff working in the surgical services for the period April 2016 to September 2017.

<table>
<thead>
<tr>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td></td>
</tr>
<tr>
<td>Average fill rate – registered nurses</td>
<td>Average fill rate – care staff</td>
</tr>
<tr>
<td>Average fill rate – registered nurses</td>
<td>Average fill rate – care staff</td>
</tr>
<tr>
<td>14</td>
<td>96.09%</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>9</td>
<td>76.95%</td>
</tr>
</tbody>
</table>

(Source: The trust Committee in Common Scorecard 30 October 2017)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported an average vacancy rate of 8.9% for nursing staff in Surgery;

- Fairfield General Hospital: 4.5%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017, the trust reported an average turnover rate of 1.0% for nursing staff in Surgery;

- Fairfield General Hospital: 0.7%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average sickness rate of 5.4% for nursing staff in Surgery, which is above the overall trust target of 4.6% for sickness rates.

- Fairfield General Hospital: 8.9%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The senior leadership team told us that sickness was being monitored and managed by the human resources team and occupational health. They recognised a need to monitor staff rotas including use of bank and agency to support substantive staff.

Two advanced nurse practitioners had been recruited and had been in post for six weeks and there were two lead nurses in theatres.

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

At the time of inspection there were adequate numbers of staff on the wards. Any shortfalls in substantive staff were supplemented with bank or agency staff.

From the safe staffing figures issued in the trust’s Committees in Common meeting, in October 2017, surgical wards average fill rates for registered nurses and carers were lower than the safe target during the day and at night on one ward. Fill rates for registered staff on another ward were within safe levels although care staff were below both during the day and at night.

At the time of inspection, staffing levels were in line with Association of Perioperative Practice (AFPP) guidance in theatre.

During the day, we were told that the assistant director of nursing / matron monitored staffing levels for the hospital. Wards were contacted to confirm staffing for the day and review the rest of the week. An on call manager monitored weekend staffing and night practitioners reviewed night cover.

**Medical staffing**
The trust has reported the following planned and actual staffing figures for medical and dental staff working in surgical services for the period December 2016 to May 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16</td>
<td>290.65</td>
<td>313.53</td>
</tr>
<tr>
<td>January 17</td>
<td>292.65</td>
<td>316.13</td>
</tr>
<tr>
<td>February 17</td>
<td>296.65</td>
<td>316.18</td>
</tr>
<tr>
<td>March 17</td>
<td>297.65</td>
<td>315.80</td>
</tr>
<tr>
<td>April 17</td>
<td>297.15</td>
<td>315.80</td>
</tr>
<tr>
<td>May 17</td>
<td>293.25</td>
<td>315.80</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Vacancy rates

Between June 2016 and May 2017, the trust reported an average vacancy rate of 7.1% for medical and dental staff in Surgery;

- Fairfield General Hospital: -3.9% (over establishment of staff)

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between June 2016 and May 2017 the trust reported an average turnover rate of 1.5% for medical staff in Surgery;

- Fairfield General Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported an average sickness rate of 1.7% for medical staff in Surgery which is better than the overall trust target of 4.6% for sickness rates.

- Fairfield General Hospital: 0.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average whilst the proportion of junior (foundation year 1-2) staff was higher.
Out of hours there were processes in place for consultant cover. For ENT and anaesthetics there was a non-resident on call. For gastroenterology there was a consultant rota providing cover (non-resident on call) from 5pm to 9am overnight during weekdays and 9am Saturday to 9am Monday.

Records
Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Nursing care and medical records were paper-based and stored in secure notes trolleys that were accessed by keypads. Records we reviewed were legible, organised and included entries from a multi-disciplinary team of health professionals.

Staff received training in health record keeping (compliance 93%) and information governance (compliance of 93%) as part of mandatory training requirements.

An essential record keeping audit in September 2017 highlighted ‘gold standard’ for legibility, order of recording and inclusion of time and date, however; improvement was required for other areas such as evidence of patient involvement and staff identification.

Medicines
The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

The trust used an electronic system for medication prescribing and administration. This highlighted any drug allergies identified.

Pharmacists checked stock levels and on orthopaedics were based on the ward. This meant patients awaiting discharge were not delayed by waiting for medication.

Controlled drugs were checked daily and the ward managers checked weekly that daily checks had been carried out. A process was in place, trustwide to dispose of any controlled drugs not used.

We carried out sample checks of medication, in each area, and these showed that all were within their expiry dates and recorded appropriately.

Patients with similar names were issued with a coloured wristband to alert staff.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between August 2016 and July 2017, the trust reported one incident classified as a never event for Surgery.

- 9th January 2017, Fairfield General Hospital (STEIS: 2017/888/REX)

An anaesthetic block was applied to the wrong location.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incidents Framework 2015, the trust reported 24 serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between August 2016 and July 2017.

The breakdown of incident types was:

- 7 slips/trips/falls meeting SI criteria (29% of total incidents).
- 5 all other categories (21% of total incidents).
- 3 surgical/invasive procedure incidents meeting SI criteria
- 3 treatment delay meeting SI criteria
- 3 pressure ulcer meeting SI criteria
- 3 sub-optimal care of the deteriorating patient meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

The trustwide electronic reporting system was not fully embedded with a poor reporting of incidents culture.

There were a total of 197 incidents reported between May 2017 and the time of the inspection. Of these the majority were graded as either low or no harm two graded as moderate harm.

The service did not manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Staff we spoke to had not reported incidents for several years. The electronic system was implemented across the trust in August 2017 and was not fully embedded. Managers investigated incidents and shared lessons learned with the local teams at monthly team meetings or in safety briefings, however; it was not clear if there was dissemination across the trust.

An example of learning from an incident was when a patient returned from theatre escorted only by a porter. Following this, it was made a requirement that every patient is escorted back to the ward with a registered nurse.

We reviewed examples of incident investigations: these showed that a root cause analysis approach was taken with action plans in place to drive improvement.

Mortality and morbidity reviews were held monthly. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent reoccurrence.

Staff were familiar with the term ‘duty of candour’ (the duty of candour is a regulatory duty that
relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person).

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 53 new pressure ulcers, 21 falls with harm and 10 new catheter urinary tract infections between July 2016/2017 for Surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Pennine Acute Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>Total Pressure ulcers (53)</th>
<th>Total Falls (21)</th>
<th>Total CUTIs (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-16</td>
<td>2.1</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Aug-16</td>
<td>1.9</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Sep-16</td>
<td>1.7</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1.5</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Nov-16</td>
<td>1.3</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1.2</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1.1</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1.0</td>
<td>0.0</td>
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<tr>
<td>Apr-17</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>May-17</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
October 2016 saw the highest number of pressure ulcers, falls and C.UTIs recorded during the period.
(Source: NHS Digital)

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Each ward displayed information about patient safety incidents such as pressure ulcers, falls and infections on ‘open and honest’ boards. These included length of time for the last occurrences for each. From the trust’s committee in board meeting (October 2017), this organisation, including Rochdale Hospital were below their trajectory for pressure ulcers and clostridium difficile infection (c.diff).

Is the service effective?

Evidence-based care and treatment

Staff on the surgical wards used care plans and recovery pathways, in line with national guidance. However; in theatres national guidance was not always followed, for example; there was no requirement for staff to be trained in advanced life support (ALS) in recovery areas of theatre.

When considering the order of theatre lists, a patient's medical condition was taken into account. For example, patients with a diagnosis of diabetes were allocated first on operating lists in line with best practice guidance.

Staff completed venous thromboembolism assessments as needed and recorded in the patients care records. Prevention options, including the use of anti-embolic stockings were discussed with patients where appropriate.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Patients were provided with information prior to admission which told them how long they would need to fast before surgery to avoid complications.

Letters were adapted for operations expected in a morning or an afternoon. A trustwide fasting policy was in place that was in the process of being reviewed and updated.

During the inspection, we observed a patient who was delayed in attending theatre; the theatre list had been changed at short notice. This meant that the patient had been nil by mouth for a longer period than is included in the trust fasting policy. This was addressed on site.

Records showed regular dietician involvement with patients who were identified as being at risk of dehydration / malnutrition or a specific dietary need.

Patients told us that they enjoyed the food provided. Wards included trolleys where hot drinks and snacks were available throughout the day. Water jugs were available for surgery patients able to drink fluids.

Patient records included an assessment of a patient's nutritional requirements as well as fluid and food charts which were reviewed and updated regularly. The Malnutrition Universal Screening Tool (MUST) was one of the risk assessments in the patient care bundles.

The trust had implemented a diabetes collaborative programme to monitor patients that included
appropriate diet.
Patients who required support and assistance with eating and drinking were identified by discreet symbols on patient boards.
In addition, there were ways of identifying certain groups of patients with an individual need, such as coloured trays for patients’ who needed support with meals.
Meal times were protected, although relatives were encouraged to support patients with an individual need.

**Pain relief**

Staff recorded patient pain scores and managed pain well.

Staff used pain scores to monitor pain symptoms at regular intervals. Patient records showed that patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.

Patients told us staff gave them pain relief medication when needed.

Staff on the surgical wards and in theatres were supported by a specialist pain management team if required.

From the last inspection, the service was not compliant with all the recommendations of the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). A pain standards audit demonstrated some compliance, as well as mitigations, in their action plan, with national guidance including RCoA (2016) and ACSA1. Following the inspection we were told that a clinical director for pain has been appointed.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The overall risk of readmission was lower for elective surgery when compared to the England average.

However, patients that were admitted for trauma and orthopaedics surgery had a higher than expected risk of readmission for elective when compared to the England averages. Senior managers told us that there had been some coding issues that had been investigated. In addition some patients had multiple admissions for one episode of care.

The trust participated in national audits, however; no evidence was provided about audit participation at this location.

**Relative risk of readmission**

**Trust level: Elective admissions**

![Graph showing relative risk of readmission for different specialties, with England Avg. at the top.](image-url)
Between May 2016 and April 2017;

- All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology and Colorectal Surgery patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Trust Level: Non-elective admissions**

![Graph showing readmission rates for non-elective admissions](image)

Between May 2016 and April 2017;

- All patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General Surgery, Trauma & Orthopaedics and Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

(Source: HES – Readmissions (01/05/2016 – 30/04/2017))

**Fairfield General Hospital: Elective Admissions**

![Graph showing readmission rates for elective admissions](image)

Between May 2016 and April 2017,

- All patients at Fairfield General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- ENT and Urology patients at Fairfield General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at Fairfield General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
**Competent staff**

**Appraisal rates**

Between June 2016 and May 2017, 79% of staff working within the Surgery & Anaesthesia division at the trust had received an appraisal compared to a trust target of 90%.

The 79% appraisal rate applies to nursing and midwifery council registered staff, additional professional, scientific & technical staff, additional clinical services staff, allied health professionals, healthcare scientists, administrative and clerical and estates & ancillary staff.

The trust did not provide appraisal rates for medical and dental staff by specialty or division, but at provider level 100% of medical and dental staff had received an appraisal.

In Fairfield General Hospital 83% had received an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Following the inspection, we were told that the compliance rate was currently 89%.

Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.

Ward 14 included ENT patients. The ward manager told me that a tracheostomy trained nurse was assigned to each shift and specific training for staff had been sourced to train and support newly appointed staff.

The trust had introduced a nurse assessment and accreditation scheme (NAAS) to support nurses’ practice. This focused on standards of care such as pain management, nutrition and hydration, end of life care, person centred care, and infection control.

The wards were assessed in their NAAS performance and colour rated or rag (red, amber, green) rated. Ward 9 was assessed in February 2017 and ward 14 in July 2017; both were rated as green.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

On the orthopaedic ward daily multidisciplinary meetings (MDT) took place. We observed a MDT meeting where all patients were discussed between nurses, doctors, physiotherapists, occupational therapists and pharmacists with all staff being ward-based.

A mental health liaison team of professionals from the rapid assessment and interface discharge (RAID) team who were employed by a neighbouring trust were available and responded in a timely manner when requested.

A specialist learning disability nurse was available for support and guidance if required.

Records indicated that a range of professionals and family members/carers were consulted as part of discharge planning processes. There was good external MDT working which included GPs.

Patient records showed that there was regular and routine input and reviews from allied health professionals such as physiotherapists, as well as nursing and medical staff.
Seven-day services

Wards 9 and 14 were open every day. On-call services were available at weekends if needed. Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards during out of hours periods. There was also on-call cover provided by consultant surgeons who were not resident but could be contacted by telephone.

Microbiology, imaging (for example x-rays and scans), physiotherapy and pharmacy support was available on call outside of normal working hours.

Access to information

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

Staff recorded details about the care they delivered either in paper records or electronically. All records we looked at were complete, up-to-date and easy to follow.

Staff told us that information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trust's intranet.

However, staff told us that electronic systems were not always reliable which meant delays in accessing results from diagnostic tests which could delay patient treatment.

Information about quality and performance were displayed both for patients and for staff on the ‘open and honest’ boards.

Information about care and treatment was provided in discharge letters that were forwarded electronically to G.P.s and patients were provided with a copy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Data for this metric was not provided.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Written consent prior to surgery was generally obtained on the day of surgery. Royal College of Surgeons (RCS) guidance recommends that written consent be obtained during the preoperative period and be re-confirmed on the day of operation. This means that patients can consider their decision during that period.

Staff were clear about how they sought informed verbal and written consent before providing care or treatment.

Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and this was included as part of safeguarding training, which was mandatory.

We observed staff obtaining verbal consent from patients prior to providing care and treatment.

If patients’ lacked the capacity to make their own decisions staff made decisions about care and treatment in the best interests of the patient and involved the patient’s representatives and other healthcare professionals appropriately. An alternative form was in place.

Records of a medical patient, on ward 14, included review by the Rapid Assessment, Interface and Discharge (RAID) team, details of the best interest meeting that had taken place and a DoL’s application had been made. However there was no evidence of a capacity assessment.

There was a trust interpreter and translation service to assist with consent for patients whose first
language was not English. For patients with a hearing impairment, British Sign Language experts could be sourced.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

Between August 2016 and July 2017 the Friends and Family Test response rate for Surgery at The Pennine Acute Hospitals NHS Trust was 26% which was slightly worse than the England average of 29%

A breakdown of response rate by site can be viewed below.
(Source: NHS England Friends and Family Test)

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

There were patient information boards that were not consistent across the wards. Some boards had privacy blinds that covered patient details, however; these were not always in place. The boards were positioned in public areas of the ward which could affect patient confidentiality.

Detailed patient handovers and safety briefings took place in private offices, however; there were also bedside handovers for staff allocated to those patients. We were told that these bedside handovers were to introduce staff and check documentation, however; information about care was shared that could be overheard by other patients in the bays.

We observed compassionate care and positive interactions in all areas inspected, including wards and theatres.

All staff introduced themselves and communicated well to ensure patients fully understood.

We observed staff interacting positively with patients and those close throughout the wards. Staff spoke to patients sensitively and appropriately dependent on individual need.

Staff treated patients, and those close to them, with respect and dignity. They were aware of patients care needs and communicated in an appropriate and professional manner.

Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.

Patients described excellent care from all staff. This included nurses, doctors, allied health professionals and administrative staff.

Patient feedback results in the monthly NHS Friends and Family Test (FFT) showed that between 74% and 100% of patients would recommend the service to friends and family with a response rate of 27%.

Patients also told us that staff of different grades, roles and responsibilities provided superb care.

Patients and families were encouraged to provide feedback, about the clinic. Boxes were available on all wards.

Patients reported receiving excellent care and said communication from staff was very good. Thank you cards were prominently displayed.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

We observed staff responding calmly and professionally with a number of vulnerable patients on different wards.

There were specialist staff available such as mental health professionals; palliative care team, nurse specialists, and spiritual leaders.

We observed that patients attending for certain procedures were accompanied by other health professionals throughout their stay.

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

Staff involved patients and those close to them in decisions about their care and treatment.

There was a selection of leaflets and patient information available to support families if required. Family members were encouraged to attend with patients to support them if needed.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that did not wholly meet the needs of local people, for example all elective ENT and orthopaedics were based at Fairfield with no preoperative clinic.

Patients who were booked for planned surgery attended health checks prior to the operation to assess their fitness for surgery, although preoperative assessment clinics were available at North Manchester General Hospital or The Royal Oldham Hospital. All elective orthopaedics was based at Fairfield except for patients that had been identified with a history of an infection.

A range of elective surgical procedures were available, some of which were able to be done as day case procedures (meaning that patients could be discharged on the same day as the procedure).

Patients were referred to the hospital for non-elective surgery via accident and emergency or GPs. There was a critical care unit for patients who deteriorated.

A variety of services were available as part of the trust at other locations.

Average length of stay

The average length of stay for patients was generally lower or similar to the England average for both elective and non-elective surgery, with the exception of non-elective trauma and orthopaedics.

There had been a reorganisation of trauma and orthopaedics. At the time of inspection, Fairfield ward nine had increased the number of beds and was ring fenced. This meant non-elective patients were all admitted to the Royal Oldham hospital.

Trust level: Elective Average Length of Stay

Between June 2016 and May 2017;

- The average length of stay for all elective patients at the trust was 2.6 days, which is lower than the England average of 3.2 days.
- Average length of stay for Trauma & Orthopaedics, Urology and General Surgery elective patients at the trust is lower than the England average.

Trust Level: Non-Elective Average Length of Stay

![Bar chart showing average length of stay for different categories of patients.](chart.png)
Between June 2016 and May 2017;

- The average length of stay for all non-elective patients at the trust was 5.1 days, which is the same as the England average.
- Average length of stay for General Surgery non-elective patients at the trust was 4.0 days, which is the same as the England average.
- Average length of stay for Trauma & Orthopaedics and Urology non-elective patients was similar to the England average.

**Fairfield General Hospital: Elective Average Length of Stay**

- The average length of stay for all elective patients at Fairfield General Hospital was 2.4 days, which is lower than the England average of 3.2 days.
- Average length of stay for Trauma & Orthopaedics and Urology elective patients is lower than the England averages.
- Average length of stay for ENT elective patients was 1.6 days, which is the same as the England average.

**Fairfield General Hospital: Non-Elective Average Length of Stay**

- The average length of stay for all non-elective patients at Fairfield General Hospital was 2.2 days, which is lower than the England average of 5.1 days.
- Average length of stay for ENT non-elective patients was 2.1 days, which is similar to the England average of 2.2 days.
- Average length of stay for Trauma & Orthopaedics medical non-elective patients was
20.5 days, which is higher than the England average of 8.9 days.
- Average length of stay for General Surgery non-elective patients was 1.7 days, which is lower than the England average of 4.0 days.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs. There were good systems in place to meet the needs of patients whose circumstances made them vulnerable.

Patients living with a cognitive impairment, such as dementia, were assessed within the general multi-disciplinary team, nursing and medical processes. Staff used a ‘this is me’ document for patients admitted to the hospital with dementia. Ward bay areas were painted with coloured borders to help identify them and bathrooms had coloured toilet seats and rails to contrast the white walls.

The trust had implemented the ‘forget-me-not’ sticker scheme. This was a discreet symbol used as a visual reminder to staff that patients were living with dementia or were confused. They also supported John’s Campaign for dementia patients. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.

Different coloured wristbands also identified patients that may be vulnerable.

Ward staff carried out enhanced monitoring of patients if assessed as at risk of harm due to vulnerable circumstances.

Wards advocated protected meal times to allow appropriate care and treatment at those times.

For patients identified with a learning disability, a passport was completed that included key information such as the patient’s likes and dislikes. This could be completed during the pre-operative stage of a patient’s care to ensure any reasonable adjustments which were needed were put in place. A learning disability nurse was available to support staff and patients. The day case ward liaised with the preoperative clinic regarding any vulnerable patients. Environmental assessments and visits took place to prepare patients for their surgery.

On the day case ward, patients receiving palliative care or patients who may be vulnerable were sensitively offered / allocated a side room.

Patients attended for mental health treatments; they were accompanied by a mental health nurse who supported them throughout the treatment.

Lockable patient property lockers were available on the day case ward so patients could secure belongings during their stay. Patients having minor procedures were nursed on recliner chairs. Patients could be nursed on theatre trolleys for up to four hours and beds were available for other day case surgeries for up to eight hours duration.

Discharges from the day case ward were nurse led. Medication stocks of take home drugs were stored on the ward.

If any patient could not be discharged, unexpectedly, following day surgery, they were transferred to the adjoining ward overnight.

There were no facilities on day case for bariatric patients, although the trust had a process to obtain equipment from other wards.

In the event of a complication, following surgery, there was a consultant of the day on call that could be contacted. This doctor was usually the second on call anaesthetist for critical care.

The orthopaedic ward 9 had increased capacity from 10 beds to 28. The ward was ‘ring fenced’ which meant that any patient that had been identified as MRSA positive, was not able to be admitted to the ward. At the time of inspection, a patient was planned to be transferred to the high dependency unit following surgery. It was explained that when the patient was expected to be transferred back to the ward, they would be nursed in a side room until it was confirmed that the
patient was MRSA negative. This was part of the national Getting it Right First Time (GIRFT) programme.

The trust had an interpreter and translation service for patients whose first language was not English. This service provided face to face, telephone interpreting and British Sign Language interpreting and translation services when needed. Translation services also included braille and alternative formats.

Patient leaflets, available on wards, were written in English, although instructions on the reverse indicated they could be sourced in languages other than English.

A mental health liaison team of professionals were available and responded in a timely manner when requested.

Spiritual support was available if needed. A chapel was available to all who wish to pray or be quiet. This facility was open 24 hours. There was also a prayer room with a women's area, which could be used for Muslim prayers. This facility was also open 24 hours.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance
Between August 2016 and July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for Surgery has been consistently better than the England average.

As of July 2017 73% of patients were treated within 18 weeks compared to the England average of 70%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
A breakdown of referral to treatment (RTT) rates for Surgery broken down by specialty is below. Of these, three of the specialties were above the England average and three of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>96.1%</td>
<td>74.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>85.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>81.9%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>74.8%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>66.9%</td>
<td>77.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>65.2%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>62.4%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

People could access some surgical services when they needed it. Waiting times for treatment and arrangements to admit treat and discharge patients were in line with the England average, with the exception of urology. However, these were below the trust targets.

From the trust’s Committees in Common dashboard October 2017: In August 2017 the RTT was 92% and in September it was 93%. The target of 92% had been achieved. (Includes Rochdale as
reported across the care organisation).

The trust had carried out waiting list initiatives and were prioritising patients according to clinical urgency.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Between Q2 and Q4 15/16, the trust slightly improved performance so that no patients had to wait longer than 28 days for treatment after their operation was cancelled. This was despite the number of cancelled operations rising during the period from 191 to 308.

However in Q1 16/17 performance declined so that although the number of cancelled operations had reduced to 215, 8% of those patients were not treated within 28 days of their cancellation.

The declining trend has continued until Q1 17/18 and 8% of the 326 patients whose operation was cancelled, did not receive treatment within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**

- **The Pennine Acute Hospitals NHS Trust**

Over the two years, the percentage of cancelled operations at the trust showed an overall trend of decline. Q1 and Q2 16/17 saw some improvements, although there has been deterioration since. Throughout the period the percentage of cancelled operations was generally higher than the England average.

Cancelled operations as a percentage of elective admissions includes only short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - The Pennine Acute Hospitals NHS Trust**

(Source: NHS England)
A number of operations were consistently cancelled for non-clinical reasons. Between April 2016 and June 2017, there were 11 patients that had been cancelled and rebooked within 28 days of the cancellation, although there was an average of 27 operations cancelled monthly for non-clinical reasons.

Between August 2017 and October 2017, a total of 199 operations were cancelled on the day with either the list overrunning or patients not attending preoperative assessment clinic as the most common reasons for cancelling. Cancellations were reviewed at monthly governance meetings.

Between June 2016 and May 2017, 92% of patients stayed in the ward they were allocated. There were 8% of patients that moved beds once and 1% that moved twice. Of these, there were 145 patients that were moved at night. Some patients were admitted to the surgical triage ward and then moved to other wards.

Between August 2017 and October 2017, there were 499 patients identified as medical outliers in the surgical wards. At the time of inspection, staff we spoke to told us that all medical patients had been reviewed regularly and no reports of difficulties in accessing appropriate medical support.

Information received from the service showed that between April 2016 and June 2017, the theatre utilisation was consistently below the target of 85%; between 75% and 79%.

Learning from complaints and concerns

Summary of complaints

Between June 2016 and May 2017 there were 257 complaints about surgery (31.6% of all complaints).

The trust took an average of 64 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 working days. As of 22 June 2017 there were 65 complaints still open and yet to be completed.

There were 109 complaints regarding clinical treatment, this was the category with the greatest proportion of complaints at 42%.

Fairfield General Hospital: There were 20 complaints (7.8%)
(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

The service did not always investigate complaints in a timely manner as per their policy. From the division of anaesthetics and surgery quality and patient experience committee meeting minutes in August 2017, there was recognition of a need to reduce the long waiting of between 70 and 100 days.

Information about complaints procedures were available in all wards we visited. There were details on cards and leaflets about the patient advice and liaison service (PALS).

Complaints were recorded on the trust-wide system. Local ward managers were responsible for investigating complaints in their areas.

Information from the trust showed that between July 2017 and October 2017, a total of 13 complaints had been received, however; this information did not include any details about individual complaints.

Lessons learnt from complaints were shared at safety huddles and ward meetings. It was not clear if lessons were shared across the trust.

Is the service well-led?
Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There were clearly defined and visible leadership roles across the surgical division. The senior management team included a divisional managing director, a divisional clinical director, and a divisional director of nursing. These managed the hospital, along with Rochdale, that was also one of the trust’s locations.

The divisional leads were supported by a team of matrons and ward and theatre managers. The length of service of the leads varied and it was not clear how embedded the service was with the changes in leads. There had been a number of interim managers; this meant that leadership had not always been stable.

Matrons were visible, in all areas, on a daily basis on the wards and attended safety huddles to ensure safe numbers of staff for the acuity of patients.

Medical and nursing staff understood management reporting structures and told us they were well supported by their managers.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The surgical service group mission statement was: “Saving Lives, Improving Lives” by delivering highly reliable services at scale, which are trusted, connected and pioneering.

The surgical division had an operational plan that included strategic themes and a plan of priorities in implementing the strategies.

The values of the organisation were displayed in areas throughout the service for staff and patients to see.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The culture of the surgical division was aligned with the trust values. There was an open and transparent culture that encouraged the reporting of incidents in order to learn from them and improve care quality for people in the local population, although there was recognition from senior managers that this could be improved.

There was a positive attitude and culture within the surgical care group where staff valued each other. Staff from all specialities reported good team working and a sense of pride in serving the local community.

The length of service of staff we spoke with varied but all demonstrated strong commitment to the hospital.

Governance

There had been a number of senior management changes, therefore; it was not clear if fully embedded systems and processes were in place.
At the time of inspection, there was no consistency in electronic systems across the trust, for example the electronic EWS boards, for monitoring patients had been implemented on surgical wards at Fairfield only with other electronic systems implemented on surgical wards at Oldham. A clinical governance system was in place within the surgical division that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. Clinical governance / audit meetings took place bi monthly: regular agenda items included review of NICE guidelines, local / national audits and mortality reviews. The divisional assurance framework fed into the board assurance framework (BAF). The BAF policy had been ratified in January 2017. The trust collected data to monitor and improve performance. Theatre dashboards captured compliance of five steps to safer surgery in real time. Audits of WHO compliance were carried out twice yearly, although they captured both adults and paediatrics trustwide. The trust had recruited a surgical surveillance nurse to monitor surgical site infections.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There were risk registers for orthopaedic and ENT surgical departments. These included control measures although not all were fully controlled. Senior managers were clear about their roles and there was evidence that quality and risk were managed appropriately.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Paper patient records were securely stored in locked trolleys. Some records were electronic and accessed by staff only.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. ‘Glimpse of Brilliance’ notice boards recognising staff contribution and efforts and also an employee of the month were recognised. Staff told us that they attended monthly ward meetings and received information at daily safety briefings. Staff information was displayed in office areas. A weekly bulletin was issued trustwide for staff updates. Senior managers told us that there were walkarounds in theatres and on the wards. The surgical division participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed in ward areas either in leaflets or boxes.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.
The orthopaedic ward had increased in capacity, with enhanced recovery pathways in place. Senior managers told us that there were plans to extend the services offered that will be available across the region.