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

Tameside and Glossop Integrated Care NHS Foundation Trust is an integrated acute and community trust based in the borough of Tameside in North West England. The trust transitioned to an integrated trust in September 2016.

The trusts has one acute hospital, Tameside General Hospital, details of which are below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tameside General Hospital</td>
<td>Fountain St, Ashton-under-Lyne, OL6 9RW</td>
<td>Full range of medical services including acute and urgent care, medical care, surgery, children and young people, maternity, gynaecology, outpatients, diagnostics, end of life and critical care.</td>
<td>Currently the trust serves a population of around 250,000 people living over an area of around 40 square miles, across both rural and urban settings.</td>
</tr>
</tbody>
</table>

The trust also provides community healthcare services for Tameside and Glossop, which are predominantly delivered from 22 community premises and in people’s homes. Community services provided include services for adults, inpatients, end of life care and children, young people and families. The trust does not provide any community dental or sexual health services.

(Source: Routine Provider Information Request (RPIR) – Sites tab / CHS Routine Provider Information Request (RPIR) - Context CHS tab)

Tameside and Glossop Integrated Care NHS Foundation Trust serves a population of 250,000 living over an area of around 40 square miles, across both rural and urban settings. The trust employs about 3,800 staff, has 524 beds across 28 wards and departments, 300 volunteers and has an annual turnover of £215 million.

The trust also provides community healthcare services across five neighbourhoods in Tameside and Glossop. These are delivered in community locations and in people’s homes, throughout the locality. This includes the Stamford Unit which is a 96 bed community facility to support patients who are determined to be medically fit for discharge. These are patients requiring further support in a non-acute setting to be assessed and discharged into their normal place of residence.

Services are predominantly commissioned by Tameside clinical commissioning group and Metropolitan Borough Council which combined to become one organisation.

Nationally, Tameside is 34th out of 326 most deprived local authority. It has the highest premature death rate for heart disease in England. In adults, the recorded diabetes prevalence, excess weight and drug and alcohol misuse are significantly worse than the England average. Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average. Healthy life expectancy for males is 57.7 years compared with the national average of 63.4 years; for women the healthy life expectancy is 58.3 years against a national average of 64 years.

The population is predominantly white British (91%).
The trust has been inspected previously. It was rated as inadequate in 2014, requires improvement in 2015 and, at the last inspection in 2016, was rated as good.

Community services were not part of the trust at the last inspection. The trust acquired community services in 2016. They have not previously been inspected under this provider.
Is this organisation well-led?

Leadership

The board demonstrated high levels of skill, knowledge and integrity to lead the organisation. There was a stable and experienced executive team. All the executive posts were filled and most of the team, including the chief executive, had been in post since 2014. The chair was appointed in 2018 and was an experienced NHS non-executive director. The director of nursing and integrated governance was appointed in February 2019 and the director of estates and facilities was appointed in March 2019; both were experienced NHS senior managers.

The executive team were delivering good operational performance as well as being focused on the development of the local integrated care system. There was evidence of compassionate, inclusive and effective leadership throughout the organisation. Partners also reported significant leadership from the executive team in developing the understanding of the integrated model across the Tameside and Glossop. There was a recognition and development of shared system leadership.

The unitary board had relevant operational, commercial and financial experience across the non-executive directors. There had been a conscious decision a couple of years previously to develop the skill set of the board to be able to support the integration agenda. The board were clear about the challenges for the trust. For example, all board members who were interviewed on the inspection visit were well sighted on the financial challenges of the trust with robust arrangements for board oversight of the trust’s financial plan. We found the governors we spoke with were very engaged with the trust’s priorities. The governors were clear about their role and effective systems were in place for them to hold the non-executive directors to account. This included the non-executive directors providing presentations directly to the governors at their general meetings and governors observing board sub-committees. Both the executives and governors spoke positively about the opportunity for constructive challenge at board level. There was good support for the integrated care model; the council leader was on the board of governors at the trust.

There was regular protected time for board development. The executive team demonstrated a good understanding of each others qualities and team dynamics; they had undertaken some self-analysis including exercises for self awareness and to inform professional development. Each alternate month to the board meeting was used to discuss and debate, mainly, specific topics. The new chair had identified that board development could be further enhanced and an external board development programme had been commissioned.

The board were considered visible and approachable across the staff teams. There was a programme of visits by executive and non-executive members. Reports from the walkarounds were reported to the quality and governance committee. We spoke with staff groups and most of the staff were aware of the executive team and were positive about their visibility.

The trust met the Fit and Proper Persons Requirement (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. There was a comprehensive fit and proper persons policy, the board completed annual declarations and there was a report on compliance submitted to the board in November 2018. An internal audit report on compliance with the Fit and Proper Persons Requirement had been undertaken in October 2018 and had reported substantial assurance.

We looked at a sample of executive and non-executive director employment files and found these were completed in line with the FPPR regulations.
The trust was managed through three operational divisions. These were the division of medicine and clinical support, division of surgery and women and children and intermediate tier services. Each division was led by a triumvirate consisting of a clinical lead, nursing and allied health professional lead and general manager. The trust had adopted a business partner model in supporting the divisional teams and this was working well, for example, with the finance team reported as adding value.

As part of the integrated care model, the trust had employed clinical directors in the neighbourhoods. They worked part-time in the trust and part-time in neighbourhood GP roles. They worked across the acute and community parts of the organisation. They led on specific transformation projects and reported their roles to be forward-thinking and had felt welcomed at the trust.

The trust had a talent management strategy that had been in place since June 2018. The strategy incorporated a talent management tool which was used to assess individuals on their past performance and their future potential. The tool had been used by the executives, their deputies and divisional directors. The tool was being rolled out across the organisation. We were informed by members of the executive team that there were succession plans developed or being developed for their roles. The trust recognised there was more to do on the resilience of its clinical leadership arrangements and was supporting a range of leadership development training opportunities to address this need. The trust had recently established associate medical director roles, reporting to the medical director to strengthen this position.

There was an intelligent approach to succession planning and identifying the skill sets required for non-executive roles. Executive directors were aware of the absence of representation from the Black and Minority Ethnic groups and this was being considered as part of the succession plans.

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 30.0% were female. Of the non-executive board members none were BME and 40.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>70.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board tab)

**Vision and strategy**

There was a clear vision and credible strategy to deliver high-quality sustainable care to people. Robust plans were in place to deliver the strategy.

The trust had a clear vision to improve health outcomes for the population of Tameside and Glossop and to influence wider determinants of health, through collaboration with health and care partners.

The vision was supported by a five year strategic plan for 2017 to 2022 entitled ‘Beyond patient care to population health.’ This was aligned to the national Five Year Forward View and the
Greater Manchester plan. The strategy had clear aims to improve population health, provide high quality services, develop and retain it’s workforce and be sustainable. Annual plans were developed from the strategy.

The trust had worked together with clinical commissioning and local authority partners to set out their ambition for the health and care system to improve life expectancy in Tameside and Glossop to match the Greater Manchester and the national average. There was a plan, ‘Care Together,’ to transform the way in which services cared for, involved and supported the residents of Tameside and Glossop, to improve health and wellbeing. There were 26 transformation schemes in place or in progress to support the strategic plan and there was early indication of the positive impact. For example, there had been a 100-day challenge, regarding diabetes, held in one of the neighbourhoods identified has having high levels of people living with pre-diabetes. Data showed following the 100-day challenge, where 131 people attended events including health checks, 49% of people from two practices that were re-tested were no longer coded as pre-diabetic.

The strategic direction was clear and the commitment and engagement to integrated working across the local economy was positive and cohesive. The metropolitan borough council and the clinical commissioning group in Tameside were led by one chief executive and there were monthly local executive team meetings between them and the trust. The trust were committed to integration and had taken positive steps to understanding the challenges across the system. It was recognised by partners in the metropolitan borough council and the clinical commissioning group that there had been a significant change from the separate local authority and district general hospital model to the current integrated model.

The strategy was also connected to the Greater Manchester Health and Social Care devolution agenda with its focus on standardising the model of acute hospital care. The trust had representatives on a number of thematic groups for the Greater Manchester programme. The chair was a member of the Greater Manchester Health and Social Care programme board and the chief executive was the deputy chair of the Greater Manchester provider federation.

The trust’s annual operational plan was linked to the delivery of strategic objectives and delivery of this was tracked by the board. Operational teams were engaged in the development of annual delivery objectives through the business planning process. The appraisal system linked to the trust and local strategy and objectives.

There was a range of supporting strategies including a clinical strategy, seven day services strategy, patient experience strategy, workforce strategy and quality improvement strategy. The workforce strategy had been developed jointly with the local authority in 2016 and was due to be reviewed in 2019. At the time of our inspection, a new strategy was being developed for medicines optimisation. The chief pharmacist told us they planned to share progress against the delivery of this strategy with all staff.

The trust has a challenging underlying deficit. The reasons for this had been subject to analysis and were understood by the board and the wider integrated care system. There was cognisance of the need to develop a more sustainable financial plan for the medium term and this work was scheduled to be completed in 2019 in line with NHS planning requirements.

**Culture**

There was a culture to support the delivery of high-quality, sustainable care. Staff across the organisation spoke positively about the culture of the organisation.
Feedback from staff we spoke with across the organisation indicated they felt supported and proud to work at the trust. Staff commented that they felt the trust had changed completely, for the better, over the past few years.

The trust undertook a quarterly staff friends and family test with some additional questions to test the trust culture. They had also used a cultural barometer in areas highlighted by the staff survey results. The results of these were used to inform action plans which were led at directorate level. Results of the cultural barometer feed into the service quality and operational governance group.

Leaders felt the trust board took their equality and diversity responsibilities seriously. Required assessments had been undertaken. An equality and diversity implementation group was in place and reported to the workforce committee, a sub-committee of the board. The implementation group was multidisciplinary with an open invite; membership included governors, chaplains, and staff side.

The equality and diversity agenda was supported by a human resources business partner as part of their role. There had been recognition of the need for further resource to support this and there had been recent recruitment to a full-time role. This post-holder would work closely with the newly appointed head of patient experience, who led on the equality and diversity agenda for patients.

The directors were aware of how the workforce compared to the local population with regard to diversity. Some staff grades representation of, for example, black and ethnic minorities, was higher than the staff grades than the local population, but the trust recognised there was further work to do. They had ambitions to tailor the workforce to reflect the neighbourhood populations. There had been agreement to produce an overarching equality and diversity strategy and staff would be involved in the development.

There were no specific staff networks in place for those with protected characteristics. This had been suggested, but staff did not feel these were appropriate. The trust had advertised for ‘diverse, fair champions’ in accordance with suggestions from the implementation group.

There was a freedom to speak up guardian. Staff had raised concerns with the guardian and these were managed and responded to by the trust. We were provided with an example of issues raised and how these had been addressed by the trust. The guardian reported that the numbers of concerns raised was below average when compared to other trusts.

The freedom to speak up guardian had access to the executive team and had presented a report to the board in September 2018 in accordance with national recommendations. A freedom to speak up strategy was in place.

As of March 2017, Tameside and Glossop Integrated Care NHS Foundation Trust employed 4,168 people, of which:

- 81% were women.
- 28% were aged between 51 and 60 years, 6% were aged between 61 and 70 years and 0.8% were aged under 20 years.
- 4% of staff disclosed that they considered themselves to have a disability, 75% of staff told the trust they didn’t consider themselves to have a disability and the remainder chose not to disclose.
- 73% of staff disclosed as Heterosexual and 25% chose not to disclose.
• 52% of staff considered themselves Christian and 23% chose not to disclose their religion or belief.

(Source: Routine Provider Information Request (RPIR) – P100 Review of the Workforce Protected Characteristics September 2018)

The trust provided the following breakdowns of medical/dental, nursing/health visiting, nursing/midwifery and allied health professional staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff</th>
<th>Qualified nursing &amp; health visiting staff</th>
<th>Qualified nursing &amp; midwifery staff</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British/Irish/Any other white background</td>
<td>34.4%</td>
<td>86.2%</td>
<td>95.4%</td>
<td>89.2%</td>
</tr>
<tr>
<td>BME British</td>
<td>27.8%</td>
<td>7.5%</td>
<td>3.8%</td>
<td>8.3%</td>
</tr>
<tr>
<td>BME Non-British</td>
<td>34.1%</td>
<td>6.0%</td>
<td>0.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Not stated</td>
<td>3.7%</td>
<td>0.4%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Staff Diversity tab)

NHS Staff Survey 2018

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.
Workforce race equality standard (WRES)

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of 2018, the following ESR staffing indicator shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

- In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (25.9% of BME staff compared to 34.7% of White staff). This has increased by 8.6% compared to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

- 37.2% of BME staff experienced harassment, bullying or abuse from staff in the past year (2018 NHS staff survey) which was significantly higher when compared to 27.0% of White staff. The score remained similar to the previous year, 2017.
- 74.2% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 83.2% of White staff. The score remained similar to the previous year, 2017.
• 20.5% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 6.3% of White staff. The score had remained similar when compared to the previous year, 2017.

• There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

Focus groups had been held with staff from black and ethnic minority backgrounds following the results of the staff survey as this had indicated there may be an issue with bullying. Directors reported that the feedback was that there was not an issue with a bullying culture, but it was a reflection of values and behaviours of some managers. Managers were being supported with human resource training including unconscious bias training. Reviews had also been undertaken regarding staff with disabilities.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care from January to December 2018.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from November 2017 to October 2018 were consistently higher than the England average. The sickness absence rates at the trust followed a similar trend to the England average with higher rates in the winter months from November 2017 to February 2018.

The directors were aware of the sickness absence rate and had found the higher rate was due to the level of long-term sickness absence. They were aware of the main reasons for absence which include musculoskeletal related issues. The trust had identified a number of actions that were being put in place to support staff and managers to reduce the sickness rate.

(Source: NHS Digital)

In the 2018 General Medical Council Survey the trust performed worse than expected for three indicators (clinical supervision, teamwork and clinical supervision out of hours) and the same as expected for the remaining 15 indicators.

(Source: General Medical Council National Training Scheme Survey)

We met with the guardian for safer working during the inspection. They produced quarterly and annual reports which reported through the quality and governance committee. They reported the number of exception reports had been static over the previous year and the number of reports was similar to other organisations.
Governance

There were clear responsibilities, roles and systems of accountability to support good governance and management.

The trust had a clear reporting structure with an audit committee, finance committee, quality and governance committee and workforce committee which were subcommittees of the board. The subcommittees were chaired by non-executive directors. The subcommittees produced summary reports for the board. There was also an executive management team meeting which supported the chief executive with the implementation of specific strategies and reported by exception to the board.

We reviewed the minutes of the quality and governance committee form November 2018. We found these were detailed and included discussion about key quality issues for the trust such as the mortality indicators and a ‘deep dive’ in relation to one of the other significant risks.

A service quality and operational governance group reported to the quality and governance committee. There were a number of groups that reported into the service quality and operational governance group. These included the integrated medicines optimisation group, mortality steering group, patient experience group, infection prevention committee, divisional governance forums and clinical audit and effectiveness group.

The finance committee predominately focused on financial performance in recognition that this was a key challenge for the trust. However, there was good crossover of membership across the quality and workforce committees. The committee undertook in-depth scrutiny of the financial position and senior operational managers attended on a deep dive basis.

The chief pharmacist was accountable to a divisional director of operations and there were clear lines of escalation to the trust board. The trust had outsourced some of their medicines supply to homecare providers and this was governed and managed appropriately.

There was an annual review of the committee structure against the terms of reference. The workforce committee had been introduced in 2018 as a result of a review.

The governance arrangements for the integrated care system were extensive, but appeared well understood by the operational teams. There was a range of transformational programmes to support the Care Together programme. These reported into a programme leads meeting through to the executive management team and relevant subcommittees of the board. The effectiveness of the governance arrangements for the transformation programmes had been subject to external review in the autumn of 2018. The review had reported significant assurance.

The council of governors was well populated and has amongst its members the leader of the local council and a representative form the trust’s PFI management company.

It was reported that budgets were set on a realistic basis with oversight from the executive led finance scrutiny group and opportunities for regular engagement with the operational teams on financial matters. There was a structured approach to setting the cost improvement plan which was managed internally across the senior operational and finance teams. The trust has made good use of model hospital in identifying efficiency and productivity opportunities and this was presented positively to the wider organisation as a key part of its improvement programme. There was a quality impact assessment process involving both the director of nursing and medical director.

The trust had a good standard of costing. They had received an external assessment which concluded there was substantial assurance regarding its costing processes and compliance with healthcare costing standards.
There was a risk-based approach in setting the annual internal audit plan and some good practice was evident in the oversight from the audit committee. The relevant senior lead attended the audit committee to outline the action plan to address any audit which received limited assurance and there was monitoring to ‘close the loop’ with any internal audit recommendations.

We reviewed a sample of serious investigation investigation reports as part of the inspection. In those we looked at, we found there was an appropriate investigation, action planning and opportunities for learning shared. The trust produced a monthly newsletter called ‘closing the loop.’ This shared information across the trust including learning from incidents, complaints and audits.

There was a ward accreditation scheme in place across the trust. It was recognised it was nursing focused and there had been discussions to broaden this to include other health professional involved in care delivery.

**Board Assurance Framework**

The trust provided their Board Assurance Framework, which details six strategic objectives within each and accompanying risks. A summary of these is below.

- **Objective 1:** To ensure our patients and users receive harm-free care by improving the quality and safety of our services through the delivery of our Quality and Safety programme.

- **Objective 2:** To improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.

- **Objective 3:** To continue to recruit and retain talented individuals whilst developing our staff and future workforce to support the integration and transformation of our services.

- **Objective 4:** To enable our five primary care neighbourhood hubs and key partners to deliver new integrated service models in order to improve the health and well-being outcomes for our communities through supporting people-
  - to prevent ill-health and live healthy, independent lives where possible;
  - to manage any on-going health conditions more effectively in their own homes and communities;
  - to facilitate easy access to joined-up services in the most appropriate location.

- **Objective 5:** To deliver against the required national regulatory frameworks and agreed local standards, in terms of quality, access and financial performance.

- **Objective 6:** To access available technologies and research to improve the outcomes for our patient population.

*(Source: Trust Board Assurance Framework – November 2018)*

The board assurance framework was reviewed at each board meeting. This was reviewed by the board in tandem with the corporate risk register to ensure board visibility of the significant operational risks. There appeared to be good alignment between the corporate risk register and the strategic risks on the board assurance framework and the non-executives provided examples
of challenge in respect of emerging issues which indicated the risk management process was dynamic.

Management of risk, issues and performance

The trust had a risk management strategy, policy and guidance. This detailed individuals responsibilities regarding the management of risk in the organisation.

The service quality and operational governance group, which reported to the quality and governance committee, had delegated authority for managing the corporate significant risk register. This group was chaired by the director of nursing and integrated governance and had clear terms of reference. There was also an executive led risk management group that reported to the quality and governance committee. The function of this group was to develop and maintain the corporate significant risk register and ensure actions were being taken. It also coordinated and maintained the review of the board assurance framework. The significant risks on the board assurance framework were assigned to the relevant board sub-committee.

The process for escalating and de-escalating risk within the organisation was well understood by the operational and executive teams. Appropriate actions were taken to mitigate known risks. For example, the system for managing Patient Group Directions (PGDs) had recently been improved to give better oversight, and this risk had been removed from the register.

All staff members had access to the trust’s risk management system for flagging risks and adverse incidents. All significant operational risks were captured on the corporate risk register.

The ownership of risk within the integrated care system was clear. Although teams were integrated and worked alongside staff from the local authority, the lines of accountability were clear with staff reporting through their own management structure. The risks identified for the trust were their own internal risks or the potential impact of external risks.

The trust had been identified as mortality outliers in sepsis, myocardial infarction and cerebrovascular disease (stroke) in September 2018. The leadership team were fully aware of the outliers and had undertaken significant work to understand and gain assurance about any risks and the quality of patient care.

The trust had responded to identified risks. For example, the ‘getting it right first time’ review had identified risks relating to a small number of procedures undertaken at the trust. As a result, the trust had stopped undertaking these to maintain patient safety. The trust was reliant on partnerships with other hospitals across Greater Manchester to provide resilience for some clinical services.

There was a monthly performance review process with the divisional teams through the operational group board. This is chaired by the chief operating officer and the other executive directors also attended.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£212.4m</td>
<td>£212.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£13.3m)</td>
<td>(£23.7m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£226.4m)</td>
<td>(£235.3m)</td>
</tr>
</tbody>
</table>
Budget (or budget deficit) | (£17.3m) | (£24.3m) | (£19.1m) | (£27.9m)

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

All board members who were interviewed on the inspection visit were well sighted on the financial challenges of the trust with robust arrangements for board oversight of the trust’s financial plan. There was reasonable confidence in the delivery of the agreed financial target for the current 2019/20 financial year. The board recognised the need to develop a more sustainable financial plan for the medium term and this work was scheduled to be completed in 2019 in line with NHS planning requirements.

The trust had a good track record of delivering agreed financial targets. It has agreed a target for the current 2019/20 financial year, albeit this was a deficit position supported by system sustainability funding. The board were reasonably confident of delivering on the financial target for the current year.

However, there remained a risk to the financial sustainability of the trust in the medium term. The board were sighted on this risk and planned to address it through the development of a sustainability plan in 2019.

**Trust corporate risk register**

There was a clear process for identifying, managing and escalating risks within the organisation. Each division had a risk register with identified risks. Divisional risks rated 15 and strategic risks, which were not included in the board assurance framework, were recorded on the corporate significant risk register. Risks that potentially affected the strategic objectives of the organisation were managed through the board assurance framework.

The trust provided their board assurance framework detailing their 12 highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk AF 1.24 (3483)</td>
<td>Increased demand for non-elective care is resulting in high levels of bed occupancy. This could result in a reduced positive patient experience and the potential to impact on workforce and finances.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Risk AF 5.1 (4059)</td>
<td>Failure to deliver Trust efficiency programme (TEP) and transformational savings.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Risk AF 5.4 (3482)</td>
<td>Medical Staffing – The ability to recruit to Consultant and middle grade posts due to national shortages in certain specialties i.e. radiology, medicine and palliative care. This may impact on patient experience and the ability to provide safe care.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Risk AF 2.2 (3485)</td>
<td>Failure to deliver 2018/19 financial plans (Capital, Revenue, Cash) approved by Trust Board</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Risk AF 2.8 (3526)</td>
<td>Failure to achieve value for money (VFM) services and financial sustainability.</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Risk AF 4.2 (3488)</td>
<td>Failure to ensure on-going compliance with terms of NHS Improvement Provider Licence requirements</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Risk AF 1.23 (734)</td>
<td>The ability to consistently sustain and maintain safe nurse staffing levels is compromised as a result of National Registered Nursing shortages. This impacts on the organisations nurse staffing vacancies and the ability to consistently deliver care hours per patient per day, high quality and safe care.</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>
If pressure ulcer prevention policies and interventions are not being consistently implemented there is a risk that patients are developing pressure ulcers resulting in avoidable patient harm. Pressure ulcer prevention may also be more challenging due to the health indices in the area.

Lack of nursing home beds in the health economy impacting on the Trust’s ability to avoid delayed transfer of care

There is a risk of delayed patient diagnosis and/or treatment as a result of lack of availability of radiologists/radiology staff in the service.

Failure to have in place an IM&T infrastructure and service supporting the organisational objectives

Cyber Security Threat: Banking Trojans now using Locky Ransomware resulting in potential data loss due to encryption

(Source: Trust Board Assurance Framework – November 2018)

**Information management**

Appropriate and accurate information was effectively produced, challenged and acted on.

There was a good range of performance information available to the board in the integrated performance report which covered clinical effectiveness, patient experience, patient safety, patient access and well-led. More detailed information was provided to the board’s committees. Sessions had been held for the non-executive directors to ensure they had a good understanding of the metrics. Executive directors gave examples of when the information had been appropriately challenged.

The board were keen to develop a range of predictive indicators and have a stronger focus on improvement trajectories. Tools had been developed and used in some areas, such as maternity and the emergency department. The emergency department forecast tool had accurately forecast demand over the past year. The information had been used to adjust medical staffing rotas to meet demand. The trust were also developing a forecast model for the summary hospital-level mortality indicator to enable early intervention.

There was a range of performance reporting available at divisional level and the trust’s business intelligence tools were reported to be robust. There was analytical support available to the divisional teams from the corporate information team and this was well regarded. The team helped with the production of meaningful data and supported staff to understand and interpret this. Information was available at individual ward level and this was being further developed to provide more ‘live’ data. Community services dashboards had been recently developed. They had been developed with engagement from partners, including the local authority, to ensure these were meaningful. There were plans to develop these further to include social care data.

Action plans were produced when performance was below expectations or had declined. Performance was benchmarked both locally and nationally.

The trust took part in NHS benchmarking to compare performance of the pharmacy service with other similar trusts. The quality of the pharmacy service was monitored using a number of key metrics. These were reported on a dashboard which was shared at divisional level to give assurance.
The trust did not have a full electronic patient records system. However, it had achieved a good level of electronic connectivity across the hospital’s IT systems and in the wider integrated care system. There are some innovative digital applications implemented by the trust providing timely health care support to local care homes and the use of apps to help patients self-manage their conditions.

Data quality reviews had been undertaken by internal audit and these have raised no significant issues. The trust has used the national data security and protection toolkit, which is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. The report was in the process of being produced.

The trust had linked with an external company to strengthen compliance with the accessible information standards. Training was about to begin at the time of inspection for the outpatients departments. The development would result in communication being tailored to the preference of the individual patient.

There was summary level financial information reported to the board covering all the key indicators. Comprehensive financial information was available for scrutiny at the finance committee including divisional analysis and a focus on forecasting and risks to the financial targets. The non-executive directors reported that they have been able to influence the design of these reports and have comprehensive visibility of financial performance.

**Engagement**

People who used services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.

The trust had an public engagement strategy which was jointly developed with the commissioning group and the local authority. The strategy outlined how local residents and stakeholders would be involved in decision making, policy development and service delivery. The strategy was overseen by the Tameside and Glossop Partnership Engagement Network. Governors and patient representatives were engaged in patient pathway redesign associated with the transformation work programmes. The trust's ambition was to develop services based on the needs of the neighbourhoods.

We saw examples where there had been public engagement, such as public engagement and consultation regarding the changes to the intermediate care provision. We also saw positive examples of how the neighbourhoods worked collaboratively with other organisations to engage with patients and arranged events held in the community. For example, 100 people attended a free ‘afternoon tea for frail patients’ where the patients were given the opportunity to feedback regarding what local community activities, including exercise classes and social activities they would like to improve their health and mobility.

The trust also had a patient and service user experience strategy (2017 to 2020). We heard examples of when the trust had listened to patients experience and implemented changes. For example, an executive spent time with a patient with autism to understand their experiences and this led to some changes in equipment availability and the environment. The trust had also recently used a tent, erected in the Hartshead building, to encourage interaction between staff, patients and relatives.

The NHS staff survey (2018) reported an overall engagement score of 7.1 which was better than the England average of 7.0.
There were a number of initiatives aimed at engagement with staff across the trust. The executive and non-executive leads used the first Friday of each month to do ‘First Friday’ walkabouts as a means of clinical and managerial leader engagement with patients to hear about their experience first-hand.

The medical director met weekly with the clinical directors. There was a rolling cycle of agenda topics, such as ‘getting it right first time’ and seven day working. Clinical engagement was balanced with sustainability. The leadership team had invested time to engage with clinicians and this had improved. Further engagement was being built, such as developing ownership of datasets including the joint registry data and engagement with ‘getting it right first time’ visits.

There was a monthly junior doctor’s forum attended by the medical director and human resources director.

The pharmacy department engaged with staff when making changes to service delivery. For example, a ‘kitchen table’ event had recently been held where staff could drop in to discuss any safety concerns they had. There were a number of positive and collaborative relationships with external partners; for example across Greater Manchester, regional Chief Pharmacist network, and other trusts.

The trust held an annual awards night for staff.

The trust had supported internships, supported by a local organisation, to provide placements for an academic year for a cohort of young students with learning disabilities. The students take part in an event at the end of their placement and produce videos about their experiences. The trust reported that some of the students were now working in paid roles within and outside of the trust.

There was well-established and effective engagement and working arrangements with local commissioners and other stakeholders. The chief executive and wider executive team had key roles in the local health economy programmes and in the Greater Manchester health and social care governance arrangements.

**Learning, continuous improvement and innovation**

The trust had progressed the integration model and there was evidence this was beginning to have a positive impact on patient experience, reducing hospital admission and supporting health and well-being. Outcomes were being monitored to demonstrate benefits. These included the digital health centre model to reduce unnecessary hospital admissions from local care homes, single point of contact for health and social care teams who were co-located providing a more streamlined service for patients, the “home first” project aimed at keeping patients at home for their care and facilitating early hospital discharge. Some of these projects had been shortlisted for national health service awards.

The trust had a well-established service transformation team which supported the transformation programme connected to the integrated care system. They supported a range of accredited continuous improvement tools to support the programmes. This was a conscious decision by the trust leadership to enable the appropriate methodology to be used for the specific improvement planned. A competency framework to support organisational improvement capability had been developed and was being rolled out across the organisation.

There were a number of innovative workstreams with medicines management, for example there was a service to refer patients to community pharmacy for medicines reviews, and a system to identify patients who were resident in social care and at high risk of repeated admission to
hospital. In addition, the trust employed neighbourhood pharmacists who consulted with patients at their usual GP practice or in their own homes to optimise their medicines and reduce the risk of admission to hospital.

The trust had a clear process for reviewing deaths of patients. Every death was reviewed using a nationally recognised tool and standard proforma. There was an executive lead, a lead doctor and lead nurse responsible for the two-stage review process. There was a secondary clinical review by a consultant, where indicated. Multidisciplinary reviews were also undertaken in certain cases to see if the death was preventable. These were fed back to clinical teams and reported to the hospital mortality group which reported to the service quality and operational governance group. We looked at a sample of reviews that had been undertaken and found these were consistent with the trust’s processes. We saw that 98% of cases had not identified care management issues, although there was recognition that some improvements could be made in the documentation. There were clear links with the incident reporting system and Duty of candour requirements.

The leadership team were fully aware of mortality outliers. They had reviewed this by looking at the quality of care and the quality of the data. It was suggested the data may have been impacted by around 5.5% due to implementing reporting changes. The trust advised the inspection team that indicators showed that mortality was reducing. They also reported they had an external review of the mortality review process.

The trust was working with a local university who had been commissioned to undertake a review of the outcomes of the integrated care system. This was due to report in 2020.

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>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>94%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>45</td>
<td>56%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60</td>
<td>72%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,874</td>
<td>(December 2017 to November 2018)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

We reviewed a sample of complaints during the inspection. We found these answered the complainant clearly and sensitively. Complaint responses were reviewed and signed by the chief executive. However, the complaints record did not always detail the lessons to be learned and assurance these had been implemented.
The trust received 433 complaints from December 2017 to November 2018. Medical care received the most complaints with 120 (27.7% of all complaints received trust wide).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of complaints</td>
</tr>
<tr>
<td>AC - Medical care</td>
<td>120</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>102</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>86</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>36</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>24</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>19</td>
</tr>
<tr>
<td>CHS - Adults Community</td>
<td>12</td>
</tr>
<tr>
<td>CHS - Community Inpatients</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>7</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>4</td>
</tr>
<tr>
<td>CHS - Children, Young People and Families</td>
<td>2</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>2</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>1</td>
</tr>
<tr>
<td><strong>Trust wide</strong></td>
<td><strong>433</strong></td>
</tr>
</tbody>
</table>

The most common subject of the complaints was clinical treatment which accounted for 153 complaints (35.3%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
November 2017 to October 2018, the trust received a total of 13,528 compliments. Surgery received the most compliments with 3,520 (26.0% of all compliments received trust wide). A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>November 2017 to October 2018</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Surgery</td>
<td></td>
<td>3,520</td>
<td>26.0%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td></td>
<td>2,970</td>
<td>22.0%</td>
</tr>
<tr>
<td>AC - Medical care</td>
<td></td>
<td>2,885</td>
<td>21.3%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td></td>
<td>1,593</td>
<td>11.8%</td>
</tr>
<tr>
<td>CHS - Adults community</td>
<td></td>
<td>675</td>
<td>5.0%</td>
</tr>
<tr>
<td>CHS - Children, young people and families</td>
<td></td>
<td>593</td>
<td>4.4%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td></td>
<td>334</td>
<td>2.5%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td></td>
<td>327</td>
<td>2.4%</td>
</tr>
<tr>
<td>CHS - Community inpatients</td>
<td></td>
<td>218</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>131</td>
<td>1.0%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td></td>
<td>126</td>
<td>0.9%</td>
</tr>
<tr>
<td>Trustwide</td>
<td></td>
<td>85</td>
<td>0.6%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td></td>
<td>51</td>
<td>0.4%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td></td>
<td>20</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Trust wide</strong></td>
<td></td>
<td><strong>13,528</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust reported it had identified that areas of the trust which experienced a greater volume of patient attendances, such as the Emergency Department and Day Surgery Endoscopy Unit also receive the highest volume of positive comments. This was consistent with the high numbers of compliments reported by these departments directly.

(Source: Routine Provider Information Request (RPIR) – Compliments)

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 of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>AC – Diagnostics (October 2018)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it’s successor Medical Laboratories ISO 15189</td>
<td>AC – Diagnostics (January 2018)</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>AC - Medical care (June 2018)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
The finance and the procurement team had both achieved accreditation at level 2 under the finance staff development programme and were working towards the attainment of level 3.
Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

The emergency department at Tameside General Hospital provides emergency care and treatment for all illnesses and injuries 24 hours a day seven days a week. There is a specific paediatric service, and daytime minor injuries and dressings clinics available. The emergency department sees approximately 88,000 patients per year, 21% of admissions were children. Patient attendances ranged from those who require resuscitation to those deemed suitable to be seen by a primary care clinician. The department consists of a multidisciplinary team compromising medical, nursing and physician associates.

(Source: Routine Provider Information Request (RPIR) – Sites tab; Acute RPIR – Context tab; Trust website)

Activity and patient throughput

Total number of urgent and emergency care attendances at Tameside and Glossop Integrated Care NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018

From August 2017 to July 2018 there were 88,215 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in the most recent year compared to the previous year. The proportions were higher than the England average in 2016/17, but lower than the England average in 2017/18.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from August 2017 to July 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, another OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

A dedicated practice educator provided mandatory training in key skills to all staff and ensured modules were completed. Training requirements were monitored weekly to ensure staff remained up to date.

Training covered a range of topics including health and safety, basic life support, information governance, infection prevention and manual handling.

Staff were allocated a time each month to complete training or update training; they did this by staggering training times, so that managers could maintain staffing levels in the department.

Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia.

The trust set a target of 95% for completion of mandatory training.

Staff had completed training in basic life support and immediate life support. The trust provided data which compliance rates were 82.2% and 91.4% respectively.

A breakdown of compliance for other mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling level 1</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>66</td>
<td>67</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>56</td>
<td>64</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall mandatory training compliance rate of 97.8% for qualified nursing staff. The 95% target was met for six of the seven mandatory training modules for which qualified nursing staff were eligible. Five of the mandatory training modules had a completion rate of 100.0%.
A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall mandatory training compliance rate of 85.9% for medical staff. The 95% target was not met for any of the six mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Safeguarding training for adults and children was part of the trust’s mandatory training programme which eligible staff must complete every three years. There were 80 urgent and emergency care staff eligible for safeguarding adults’ level 1 training, with a compliance rate of 100% for nursing staff and 92% for medical staff.

Safeguarding training children (levels 2 and 3) was part of the trust’s role specific mandatory training and eligible staff were required to complete it every three years. It was completed by all clinical staff working with children and young people. However, the trust target of 90% was not met for safeguarding adults’ level 2 and safeguarding level 3 children training module for medical staff. The trust reported the safeguarding team would continue to work with the emergency department to promote attendance at safeguarding children’s level 3 training.

The service had systems to identify and manage children and adults at risk of abuse, including domestic violence. The urgent and emergency department reported 56 adult safeguarding referrals between December 2017 and November 2018.

The safeguarding policy was available to staff on the intranet. Staff we spoke with had undertaken safeguarding training and understood how to recognise and report abuse which included specific training about child sexual exploitation, PREVENT, female genital mutilation and domestic violence.

When staff had concerns about a vulnerable adult or child they made referrals to the trust safeguarding team, who reported the concern to the local authority. This team offered a liaison service; including facilitating a weekly liaison meeting to discuss good practice and less effective responses to safeguarding referrals. Meetings provided an additional opportunity for safeguarding supervision of individual cases over and above the quarterly safeguarding supervision sessions hosted in emergency department.
Since the last inspection the department had introduced the Child Protection Information System. This national system connected the local authorities’ child social care information technology systems with the urgent and emergency departments across England, to provide better care and earlier intervention for children who were considered vulnerable and at risk. This meant staff could immediately access the system to check the child’s protection status, any risk assessments about the presenting child and details of which local authority to contact for follow up.

Referrals for children were reviewed by the emergency liaison practitioner and then transferred to the relevant Healthy Child Pathway Team for inclusion in the child's notes.

Staff had co-produced wellbeing care plans with patients who were regular attenders at the department. Alerts were on the electronic care record to highlight patient’s needs, including learning disability.

Although there was a field, which was intended to be mandatory, on every patient’s electronic record remind/ prompt staff to ask about safeguarding, staff told us that this page could be bypassed if the staff member carrying out the assessment asked the system to remind them later. Whilst on inspection we reviewed an incident relating to this; senior managers had sent out a memo to staff asking them to abide to trust safeguarding policy.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules from December 2017 to December 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>67</td>
<td>67</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall safeguarding training compliance rate of 100.0% for qualified nursing staff.

A breakdown of compliance for safeguarding training modules from December 2017 to December 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>9</td>
<td>13</td>
<td>69.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall safeguarding training compliance rate of 80.8% for medical staff. The 95% target was not met for either of the two safeguarding training modules for which medical staff were eligible.
It should be noted that the training modules not meeting the target is due to only one to four eligible staff not having completed the training, so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

The infection prevention local policy was available on the internet.

We saw that staff had access to the infection and prevention control team if they needed further information; this included a contact number and details of the link nurse.

Posters were displayed around all areas of the department about infection prevention and handwashing. There was a large wall board promoting infection prevention control for staff, patients and visitors to read.

Staff could isolate infectious patients in side rooms and signs were placed on the doors to alert people to an infection risk. We saw there were systems in place to ensure rooms were fully decontaminated and deep cleaned. For example, whilst on inspection we saw a side room being fumigated and signage on the room doors clearly informing staff of the process being undertaken.

Hand hygiene audits were scheduled monthly and data was sent to the infection prevention link nurses and the matrons. Audit results provided by the trust for the emergency department, ambulatory care unit and the integrated assessment unit are below. Areas achieving a compliance rate of less than 97% were requested to undertake a re-audit within seven days. Audits were undertaken by matrons and infection prevention link nurses from directorates outside of urgent care to ensure a more independent audit. Where audits did not take place the infection prevention team contacted staff responsible for undertaking the audit to understand why it was not completed.

<table>
<thead>
<tr>
<th>Location</th>
<th>Feb-19</th>
<th>Jan-19</th>
<th>Dec-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>no data</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulatory care unit</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
</tr>
<tr>
<td>Integrated care unit</td>
<td>100%</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Hand hygiene performance and the reasons why audits may not have been completed within the timeframe are discussed at the bi-monthly Trust-wide Infection Prevention Group. The Infection Prevention Team also raised issues of non-compliance with hand hygiene at the Divisional Quality and Safety meetings and Urgent Care Directorate Patient Safety and Quality meeting where they presented an infection prevention report. The reasons given for not carrying out audits have previously related to capacity/pressures.

We saw waste management systems were in place to ensure waste was appropriately disposed. All the sharps containers we saw were free from protruding needles/sharps and stored safely. Once yellow sharp dispensers were full they were sealed, signed and dated accurately. This was in accordance to NICE clinical guidelines CG139 February 2017 standards. Disposable curtains were utilised in the department; we randomly checked curtains across all areas of the department and found they had all been changed recently and dated correctly.

There were hand washing facilities and antibacterial gel dispensers available in the department, however they were not available in the waiting areas.
There were systems in place to keep the environment visibly clean in most areas. Staff cleaned equipment after use and a sticker was used to indicate equipment that had been cleaned. Housekeepers kept the sluice area clean and tidy and ensured commodes were cleaned and ready for use.

However, we saw areas in the paediatric waiting room that required cleaning and some toys were sticky and visibly dirty. In other areas paint was flaky and floors were stained. We saw staff did not always use the personal protective equipment provided or wash their hands before and after patient contact. We observed on twelve occasions where staff did not wash their hands after patient contact. However, all staff adhered to ‘bare below the elbow’ guidance.

Environment and equipment

The layout of the majors and minors’ areas allowed staff to directly observe patients in all surrounding bays.

The waiting area used by patients had enough seating available, which was secured to the floor. Waiting times were displayed in the waiting room, on the television monitor and behind reception. Some patients we spoke in the waiting room felt they could be overheard when speaking to reception staff.

Access to areas of the urgent and emergency department were controlled using magnetic door locks, therefore patients were unable to get in without presenting at the reception desk or being let in by staff.

The department was wheelchair accessible; entrances had ramps and the hospital had lifts to the first floor.

There were assessment rooms near the main waiting room which were used by emergency nurse practitioners, advanced nurse practitioners for triage and treatment. There was a GP triage room being built at the time of the inspection.

The new area built in the emergency department was located next to the majors area. Patients were streamed to this area if they were waiting to be seen by an emergency nurse practitioner. The waiting area housed comfortable seats and a television. There were four rooms located in this area.

The resuscitation room had six treatment bays; this included a bay which could be used for paediatric patients.

There was a separate children’s emergency department (ED) with a secure entry system, where paediatric patients went directly after registering. The children’s emergency department was small and consisted of a waiting room, four cubicles including a triage room. Children requiring a resuscitation room were seen in the adults resuscitation room.

Medical equipment assurance was derived by use of a maintenance database which was managed centrally by the estates and facilities team. Matrons had sight of service reports which reported maintenance processes and monitoring.

We had no concerns with the maintenance of equipment; from random equipment checks across the department we found all fifteen pieces of equipment had stickers showing the date the item was checked and the date the next maintenance check was due.

Trolleys were cleaned, labelled, sterile dressings were organised, and clinical equipment was appropriately stored ready for use.
Observation of the storage of cleaning equipment’s, for example cloths and mops, were correctly stored in the domestic cupboard.

We also reviewed checks for fridges storing medicines at low temperature across all areas. We saw gaps in daily records in areas of the emergency department except in the blue zone, where fridges were checked daily throughout March 2019. Trust policy instructed staff to check the fridge temperature daily to ensure a suitable range was maintained.

Resuscitation equipment contained single use equipment and was in sealed bags. All drawers were tagged, and details of the tag number had been recorded and signed. We saw that the right equipment was in place to care for adults, and children of different ages, including equipment to manage the airway, breathing and circulation.

We found adult resuscitation equipment to be compliant with safety checks and there was evidence of completed daily checklist in the blue zone, majors, resuscitation area and minors.

However, we were not assured that the paediatric resuscitation trolley was always checked according to the trust’s policy. There were three days in March 2019 when records showing daily checks had not been completed. We escalated our concerns with the Director of Nursing whilst on site who assured the inspection team actions to address this would be taken immediately. These actions included discussing the importance of checks with individual staff and adding this to the monthly newsletter.

Assessing and responding to patient risk

Patients booked in at the reception desk and waited to be called by the triage nurse for a clinical assessment, so that they could be streamed to the most appropriate area for care.

All cubicles were equipped with patient call bells; we observed call bells near to patients so that they could access them if they needed to.

The majors area had three bays for patients that were deteriorating; these were visible to the nurse in charge so that these patients could be closely observed. In addition to this, the coordinator undertook a two-hourly walk around to discuss patients’ conditions and any changes, information from this walk around informed ongoing communication with consultants.

The department followed strict criteria for managing the risks of signposting patients to other services such as the GP or ‘blue zone’ rather than seeing them in the main department. Only patients with clinical observations within normal range could be referred. Everyone else with observations outside normal range were seen in the emergency department.

Staff used risk assessments to record and act on risks of reduced skin integrity, falls, venous thromboembolism (blood clots), safeguarding vulnerability or delirium (confusion). The electronic patient record system prompted staff to consider these risks and provided further information should the risk be present.

The service included round the clock access to mental health liaison for adults and other specialist mental health support for children and young people.

Psychosocial assessments and risk assessments for patients thought to be at risk of self-harm / suicide were carried out. To support risk assessments, a resource folder for risks and processes was available in the department. For example, the folder contained risk assessments for wound care closure, for patients with dementia, visible impairments and audiology problems.
A trust policy, based on international guidance, supported staff in providing care to patients who presented with sepsis symptoms. Staff adhered to standards in the Sepsis UK, Sepsis Trust, NICE guidelines, (NG51) July 2016 updated September 2017 national guidelines when treating a patient with sepsis. We saw that staff were clear about what action they would take if they suspected sepsis which included escalation to a senior nurse with an aim to initiate care immediately.

Sepsis assessments were included on assessment documentation and completed to flag patients at risk, and a pathway was followed to provide a specified bundle of care, which included timely administration of antibiotics. During our inspection, we saw, bloods, blood cultures and venous access was immediately performed on a patient who triggered a sepsis alert within the ambulance triage. When we checked notes from this patient, we saw that staff had put together a treatment plan and they had prescribed antibiotics which were administered within the hour.

Sepsis UK, national posters and guidelines were visible in all the departments. Sepsis is a rare but serious complication of infection which can lead to multiple organ failure and death.

The hospital did not have children’s intensive inpatient facilities. As a result, very unwell children requiring inpatient care were transferred to a suitable hospital. We saw that there was a high dependency unit management of children requiring critical care and transfer to tertiary care. The policy was in date and detailed special arrangements with the North West and North Wales paediatric transport service (NWTS) and neighbouring children’s hospital that provided transfers should one be required.

Staff were familiar with the major incident process which enabled them to coordinate and manage large scale or very serious incidents in line with good practice. The major incident plan which was up to date and contained relevant information including roles and responsibilities of staff and instructions when responding to chemical incidents.

National early warning scores and paediatric early warning scores helped staff to assess, prioritise and monitor patients. From these scores staff could identify any deteriorating patients.

The service monitored patients two and a half hourly so that they could manage associated risks. Documentation prompted staff to confirm that observations had been taken, risk assessments completed, pain reassessed, and refreshments offered.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five of the Emergency Department Survey questions relevant to safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q8. How long did you wait before you first spoke to a nurse or doctor?  5.6  About the same as other trusts

Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?  5.7  About the same as other trusts

Q33. In your opinion, how clean was the emergency department?  8.3  About the same as other trusts

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?  9.6  About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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

The median time from arrival to initial assessment was better than the overall England median in seven months over the 12-month period from November 2017 to October 2018.

In November and December 2017 and February 2018, the median time to initial assessment at the trust was worse than the England average.

In January and August 2018, the median time to initial assessment at the trust was the same as the England average.

In the most recent month, October 2018, the median time to initial assessment was better than the England average at seven minutes compared to the England average of eight minutes.
Ambulance – Time to initial assessment from November 2017 to October 2018 at Tameside and Glossop Integrated Care NHS Foundation Trust

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

Tameside General Hospital

From December 2017 to November 2018 there was a relatively stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Tameside General Hospital.

The monthly percentage of ambulance journeys with turnaround times over 30 minutes at Tameside General Hospital was 50% or more in eight out of the 12 months from December 2017 to November 2018.

The monthly percentage of ambulance journeys with turnaround times over 30 minutes at Tameside General Hospital peaked in February 2018 with 59.2%. In the most recent month, November 2018, 51.8% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Tameside General Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Tameside General Hospital

(Source: National Ambulance Information Group)

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.

From November 2017 to November 2018 the trust reported 331 “black breaches”, with a downward trend over the period. The largest number of black breaches occurred in December 2017 (74). There were also high numbers reported in February 2018 (64) and January 2018 (61).

Reasons ascribed by the trust for black breaches from December 2017 to February 2018 included higher than average ambulance attendances, patient flow through the department, staffing deficiencies across the trust and patient flow out of the department.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
Nurse staffing

Each shift was led by a band 7 senior nurse, this person oversaw the department, reviewed patient status and escalated issues as necessary.

Designated nursing staff also worked in the ambulance assessment area, the triage area and the resuscitation room. At the time of inspection, there was one qualified nurse allocated for triage for the adult emergency department.

The blue zone was staffed by emergency nurse practitioners and assistant practitioners between 9-10pm. Once staff finished working in this area, they were allocated an area of the emergency department that required support. We found that this area was well staffed.

Data provided by the trust showed between April and November 2018, over 92% of shifts had the planned number of staff on duty. However, whilst most of the departments within the emergency department were appropriately staffed, there were some gaps in the registered children nursing provision.

The children’s department was staffed separately to the adult service. During the day, the area was mostly staffed with two registered children nurses. Children were triaged by a registered childrens nurse and seen in the children’s area. At night, the staffing provision was inconsistent. From rotas we reviewed between January 2019 and March 2019, the late shift was usually staffed by one qualified childrens nurse who was supported by registered general nurse and twilight shifts, were covered by an adult nurse who had received training from the trust to look after sick children. We also saw that children were triaged at night by an adult nurse in the main emergency department.

Therefore, the service did not have sufficient paediatric registered nurses to meet national recommendations for a minimum of two paediatric staff on duty at all times. For example, in January 2019, 15-night shifts were filled by an adult nurse who worked alone or supported a paediatric nurse who worked until 10pm. The trust assured us that only nurses who had completed one-day paediatric life support course were rotated to support the area.

Within the adult area, during the day, the nursing and healthcare staff were allocated to work in specific areas for the duration of their shift. Staffing in the majors area consisted of two qualified nurses and one level four healthcare support worker. The minors area was staffed with one qualified nurse and one health care assistant.

Staff in the adults emergency department felt there were enough staff to meet patients’ needs. Records we reviewed at the time of the inspection showed patient care needs were met and actions such as administering medications were completed in a timely way.

**Total staffing: planned vs. actual**

The trust reported the following qualified nursing staff numbers for the two periods below for urgent and emergency care:

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 36
The trust reported a qualified nursing staffing level of 90.5% in urgent and emergency care from April 2017 to March 2018. This increased to 92.9% from April to November 2018.

From April to November 2018, there were 5.4 fewer WTE staff in post than planned for and 1.5 more WTE staff in post than from April 2017 to March 2018. There was a decrease of 0.4 WTE planned posts between the two-time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From December 2017 to November 2018 the trust reported an overall vacancy rate of 7.1% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 8.9% for qualified nursing staff in urgent and emergency care. This was lower than the trust target of 12%.

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

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 6.2% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 4.2%.

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

Bank and agency staff usage

From December 2017 to November 2018 the trust reported 20,260.6 of the 173,569.5 available hours were filled by bank staff (11.7%) and 3,325.8 hours were filled by agency staff (1.9%) in urgent and emergency care. In addition, there were 31,376.1 hours that needed to be covered by bank or agency staff but were left unfilled (18.1%).

None of the non-qualified nursing hours were filled by agency staff. The trust gave the reason of 'vacancies' for the usage of bank and agency staff.

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank Hours</td>
</tr>
<tr>
<td>Qualified</td>
<td>13,122.2</td>
</tr>
<tr>
<td>Non-qualified</td>
<td>7,138.4</td>
</tr>
<tr>
<td>Total</td>
<td>20,260.6</td>
</tr>
</tbody>
</table>
Medical staffing

Staff reported there was a reliance on locum doctors to fill gaps in the medical rota and there were concerns about the long-term sustainability of consultant cover.

Senior managers recognised the importance of recruiting doctors and were supporting eligible doctors to undertake the certificate of eligibility for specialist registration (CESR) programme. This process allowed doctors who had not trained through the approved medical programme to demonstrate their knowledge, skills and experiences. They were then able to apply for substantive consultant posts.

Consultant cover in the department was from 8am until 10pm on weekdays. Out of these hours, consultants were on call. This was less than the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. The consultant cover in the department on a weekend was from 8am until 6pm. All staff told us that consultants were readily accessible on call and many regularly stayed after the end of their shift.

Total staffing: planned vs. actual

The trust provided the following statement regarding staffing data:

- Medical Staffing consultant reflects WTE (Some consultants will show as 1 WTE even though they work more than 10 PA’s).

The trust reported the following medical staff numbers for the two periods below for urgent and emergency care:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Medical staff</td>
<td>19.6</td>
<td>33.0</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 59.4% for medical staff in urgent and emergency care from April 2017 to March 2018. This increased to 71.6% from April to November 2018.

From April to November 2018, there were 9.4 fewer WTE staff in post than planned for and 4.0 more WTE staff in post than from April 2017 to March 2018. The number of WTE planned posts remained the same between the two-time periods.

Vacancy rates

From December 2017 to November 2018 the trust reported an overall vacancy rate of 37.4% for medical staff in urgent and emergency care. This was higher than the trust target of 4%.
Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 11.6% for medical staff in urgent and emergency care. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 3.2% for medical staff in urgent and emergency care. This was lower than the trust target of 4.2%.

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

Bank and locum staff usage

From November 2017 to October 2018 the trust reported 8,253.9 of the 68,824.8 available medical staff hours were filled by bank staff (12.0%) and 7,737.8 hours were filled by locum staff (11.2%) in urgent and emergency care at Tameside General Hospital. In addition, there were 15,992.0 hours that needed to be covered by bank or locum staff but were left unfilled (23.2%).

The trust gave the reason of 'vacancies' for the usage of bank and locum staff.

A breakdown of bank and locum usage is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Tameside General Hospital emergency department</td>
<td>8,253.9</td>
</tr>
<tr>
<td></td>
<td>12.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

As of September 2018, the proportions of consultant staff reported to be working at the trust was similar to the England average while the proportion of junior staff (foundation year 1-2) was lower.

Staffing skill mix for the 27 whole time equivalent staff working in urgent and emergency care at Tameside and Glossop Integrated Care NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Records

A system to ensure patients were seen in priority order meant that the sickness patients were seen first. Patients notes were kept in priority order, urgent, very urgent, referred to specialist and seen with a treatment plan.

Both electronic and paper documentation were utilised within the emergency department.

Patients that needed reviewing by a consultant were identified with a red star on either the electronic or paper documentation. The coordinator also kept a record of patients that needed a consultant review.

The national early warning score (NEWS) and pediatric early warning score (PEWS) was used to monitor patients. These scores are used in acute hospital settings as a tool developed by the Royal College of Physicians which allows health professionals to detect and respond to clinical deterioration in patients. We found that NEWS/PEWS were recorded for all eligible patients, and pain scores were recorded.

At this inspection we reviewed a total of 12 sets of adult notes and three sets of paediatric notes. All records we reviewed had been completed in a legible manner with staff names and designations clearly written. However, we found seven records did not contain all the information required to care for patients. For example, fluid balance charts were missing and referrals to the rapid assessment interface and discharge team.

Medicines

The department had a medicine management policy and staff could tell us about the policy and where to access it.

The trust required two qualified staff members to sign for administering certain medications including paracetamol and ibuprofen. During our inspection we found medication was checked according to the policy.
Controlled medication was stored securely; we found controlled medication checks were always signed for by qualified staff, therefore we were assured controlled medications was checked regularly.

Fridge temperatures were recorded and monitored by the department. Medicines requiring refrigeration were stored at the correct temperature to ensure they did not become ineffective. We checked this across all areas and found medicines to be in date and stored in an organised manner.

We found emergency drugs boxes to be sealed and labelled with the date of expiry. All were in date and maintained by pharmacy staff.

Medicines safety bulletins were sent out to staff via emails; this was to make staff aware of any changes or updates relating to medicines.

The antimicrobial management team undertook antimicrobial surveillance and produced a set of learning points each month for circulation to consultants.

The trust also produced an antimicrobial consumption report required under the CQUIN for NHS England.

However, we checked medicines at random across all areas and found that all were in date, with stock rotation apparent. However, we found paracetamol and ibuprofen oral suspensions were not dated when they were opened in the paediatric department.

The department did not record the ambient room temperature; therefore, they could not provide assurance that medicines were always kept at room temperature.

Incidents

Staff we spoke to knew how to report incidents, they felt the service promoted a no blame culture and supported them during the process.

Staff reported incidents through the online reporting system. We spoke to the department matron who reviewed all incidents reported on the department’s system. Themes were talked about in the monthly newsletter, so that any lessons could be learned throughout the hospital.

The clinical educator for the department used incident outcomes to influence staff teaching and training.

We reviewed three incidents and saw evidence of incidents appropriately being reviewed by senior clinical leads. Actions were followed up by managers; these included emails to support communication, training to improve awareness and competencies and reflections from staff.

Lessons learned were disseminated to the teams through staff meetings and during handover. All staff we spoke with knew about recent incidents and gave appropriate examples.

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. Staff we spoke to were aware of the duty of candour and could explain it adequately to us we saw documentation that showed it had been applied appropriately.

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.

From December 2017 to November 2018, the trust reported no incidents classified as never
events for urgent and emergency 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 nine serious
incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS
England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
<td>22.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(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 the suggested data collection
date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure
ulcers, falls with harm or new urinary tract infections in patients with a catheter from November
2017 to November 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

The hospital audited compliance with NICE guidance as part of its annual programme of clinical audit as set out in the hospital’s audit forward plan.

However, we found that the content of some policies and processes to inform staff how to care and treat patients were not up to date with evidence-based guidance and standards set by organisations like the National Institute of Health and Care Excellence and the Royal College of Emergency Medicine. For example, we saw that staff assessed stroke patients with the stroke recognition instrument (rosier) tool, information in this tool was not referenced and therefore there was no assurance that the information staff were following was up to date and appropriate. We also saw that the stroke recognition tool did not instruct staff to perform brain imaging or administer anticoagulant treatment, such as clopidogrel, as stated by NICE guidance. Staff used this tool in isolation of the stroke care bundle pathway. We raised concerns with the Director of Nursing and the clinical leads who recognised immediate actions were needed to ensure all tools and pathways were referenced with current guidance.

All staff we spoke with could access, via the trust’s intranet, guidelines, policies and procedures relevant to their role. However, on inspection we could not access several and links in documents were not working.

During inspection we saw that some patient group directions (PGDs) were not in date. PGDs are required to enable nurses to administer certain ‘prescription only’ medicines without a prescription from a doctor. We raised this with the director of nursing at the time of the inspection. During the inspection, we saw the system for managing Patient Group Directions (PGDs) had recently been improved to give better oversight.

Nutrition and hydration

Patients were given food and drinks to meet their needs and improve their health whilst in the department.

Those who were nil by mouth were kept hydrated intravenously. This was recorded electronically on the patient record.

Housekeepers provided sandwiches, soup or toast and hot and cold refreshments for patients and loved ones. We saw that they visited the patients every two to four hours depending on activity. We saw in the ambulatory unit, details of the patient’s nutritional status was documented in the patient’s care plan and visible above the patient’s beds, so it was clear to staff if the patient was nil by mouth.

Staff we spoke with said they monitored theirs of malnutrition by completing the Malnutrition Universal Screening Tool ‘MUST’. This nutritional screening tool is a five-step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. However, we saw that staff did not always complete fluid balance records; in two of the twelve records we reviewed they were absent.
Emergency Department Survey 2016

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

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Pain relief

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.

From observations we saw that pain relief was routinely offered on triage to patients experiencing pain and pain relief was proportionate with the patient’s level of pain.

Nurses used pain scores based on a scale between zero (no pain) and ten (very bad pain) or for children, a scale using sad or smiley faces to represent their level of pain.

In the patient records we saw there were pain assessment charts to support staff in monitoring pain relief for patients. Staff described, they would use their own experience to help them assess pain and use objective markers such as a raised heart rate or blood pressure.

Any administered pain relief was documented in the patients notes. Patients we spoke with had no issues with how their pain was being managed.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.4 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 7.7 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.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

The department participated in the national Royal College of Emergency Medicine (RCEM) audits. RCEM audits allow trusts to bench mark their practice against national best practice and encourage improvements.

Senior medical staff felt that poor results were primarily caused when staff did not document care in the detail required.

Staff recognised that not having a dedicated paediatric emergency medical consultant based on the department meant it was not possible to review all children who presented with fever under the age of 1 year of age.

RCEM Audit: Moderate and acute severe asthma 2016/17
In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Tameside General Hospital emergency department failed to meet any of the national standards.

The department was not in the upper UK quartile for any standards.

The department was in the lower UK quartile for one standard:

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 44.9%; UK: 77%.

The department’s results for the remaining standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Tameside General Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 25.9%; UK: 11%.

• Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 34.1%; UK: 12%.

The department was in the lower UK quartile for one standard:

• Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.

The department’s result for the remaining standard was within the middle 50% of results:

• Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 6.3%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Tameside General Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for six standards:
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. This department: 98.0%; UK: 69.1%.

Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 96.0%; UK: 64.6%.

Standard 3: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 75.0%; UK: 30.4%.

Standard 4: Serum lactate measured within one hour of arrival. This department: 76.0%; UK: 60.0%.

Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 73.3%; UK: 43.2%.

Standard 7: Antibiotics administered: Within one hour of arrival. This department: 60.0%; UK: 44.4%.

The department was not in the lower UK quartile for any standards. The department’s results for the remaining two standards were all within the middle 50% of results:

Standard 5: Blood cultures obtained within one hour of arrival. This department: 59.2%; UK: 44.9%.

Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 8.2%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within seven days

From November 2017 to October 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% in all 12 months. In the same time period, the trust’s performance was worse than or about the same as the England average in seven out of the 12 months.

The trusts performance peaked in March 2018, when the trust had a rate of 8.6% compared to an England average of 7.6%.

Unplanned re-attendance rate within seven days - Tameside and Glossop Integrated Care NHS Foundation Trust
Competent staff

Since the last inspection, we saw that appraisal rates had improved from 77% to 90.8% and had met the trust target of 90%. The service ensured that staff were competent in their roles by completing an annual appraisal, and by offering staff additional training if they required it.

Managers held monthly one to one meeting with staff to discuss any challenges and achievements, training needs and their health and wellbeing. Managers appraised staff performance biannually and held supervision meetings with them to provide support and monitor the effectiveness of the service when required.

A practice nurse educator supported nurses to maintain and further develop their professional skills and experience. Such support meant staff could maintain competencies in a range of subjects including intermediate and advanced life support and caring for the sick child.

Inductions were mandatory for newly appointed staff including locums and agency nurses. All staff were required to attend a three-day corporate induction. They then worked on supernumerary basis for a minimum of four weeks.

Induction packs were distributed to staff and supplementary sessions covering information including governance, fire safety, use of equipment, mandatory training and personal safety were offered. We saw evidence of completed induction booklets.

Staff explained that they received additional training relevant to their role. For example, the practice educator delivered Manchester triage training to nursing staff so that they could triage patients when they arrived at the emergency department.

All nurses completed national competency work books that contained national curriculum from the Royal College of Nursing. We saw evidence that completion of the workbooks was actively encouraged by senior staff and they provided assurance that competencies were being maintained.

We saw that medical staff and advanced nurse practitioners rotated around different areas of the urgent and emergency department such as resuscitation and streaming areas to help maintain competencies and knowledge.

All nurses received advanced life support training which was updated annually. Care support workers and reception staff completed basic life support. The trust confirmed that at the time of our
inspection 80% of staff were trained in basic life support and 100% of staff were intermediate life support trained.

To ensure staff could perform paediatric life support in the absence of a registered paediatric nurse, emergency department nurses were trained to provide paediatric life support and consultants and advanced practitioners were trained to provide advanced paediatric life support. The trust reported five members of staff who were not PILS trained, two of whom were Advanced Paediatric Life Support trained and three members of staff were booked on to the course.

### Appraisal rates

From April to November 2018, 90.8% of required staff in urgent and emergency care received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Other non-medical staff</td>
<td>75</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>32</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>67</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187</strong></td>
</tr>
</tbody>
</table>

It should be noted that the only staff group not meeting the target is medical staff. However, this is due to only four eligible staff not having had an appraisal, so the performance should be taken in context when dealing with small numbers of eligible staff.

*Source: Routine Provider Information Request (RPIR) - Appraisal tab*

### Multidisciplinary working

To ensure effective services were delivered to patients, we saw different teams and health professionals working together as a multi-disciplinary team (MDT).
Staff worked across health care disciplines and with other agencies when required to care for patients. This included the local mental health trust and the police.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Care support assistants worked alongside triage nurses performing diagnostic tests, such as electrocardiograph or blood tests during assessment. This helped maintain flow through the department. During busy periods phlebotomists came to offer extra support.

For major trauma care, staff in the urgent and emergency department liaised with anaesthetists, and specialist medical staff from a variety of specialisms such as orthopaedic, surgery, neurology to provide the right care for patients.

Doctors, nurses and paramedics worked closely, ensuring information was handed over as efficiently and thoroughly as possible. Ambulance staff we spoke with confirmed the team were attentive and they never experienced any difficulties with the hand over process.

Advanced nurse practitioners and assistant advanced nurse practitioners worked alongside medical staff in the emergency department providing advanced care for patients that previously may only have been provided by doctors.

**Seven-day services**

The main emergency department (including minors, majors and resuscitation areas) and the paediatric emergency department were all open 24 hours a day, seven days a week, all year round.

There was access to a 24 hour, seven days a week radiology service which was available within the department. This included the provision of x-ray and computerised tomography (CT) scanning facilities. Patients had access to diagnostic testing 24 hours a day, seven days a week throughout the year via dedicated X-ray and computerised tomography scanners which were in the emergency department.

The multi faith chaplaincy team and had representation from all major faiths. The team was available to provide specialist support for families or loved ones. They operated 24 hours a day, seven days a week, all year round.

Consultant cover in the department was from 8am until 10pm on weekdays. Out of these hours, consultants were on call.

The department had access to the hospital’s emergency theatres which operated 24 hours a day, seven days a week.

**Health promotion**

The service supported patients by promoting healthier lifestyles. Staff in the urgent and emergency department identified those who may needed extra support during assessment and helped source the right staff to help provide specialist care for them.

To help capture national priorities to improve the population’s health, staff involved in initial assessment asked patients about smoking habits and alcohol consumption. Those patients who needed support could access the hospital Alcohol Liaison Service (HALS) seven days per week between the hours of 8 a.m. and 8 p.m.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Staff understood the relevance of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

We saw that the trust had a consent and mental capacity policy although this was overdue review at the time of inspection.

Staff described how mental capacity was assessed as part of the triage and admission process and were aware of the additional steps to consider if the patient did not consent to treatment. Nursing staff we spoke with, said they would escalate their concerns about a patient’s mental capacity to medical staff for a senior medical review.

Staff we spoke with said consent was implied, but still routinely obtained verbal consent from patients. We saw staff explaining procedures to patients and gaining verbal consent.

In the children’s department, staff we spoke with were aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'Gillick Test' helps clinicians to identify if children under 16 years of age have the legal capacity to consent to medical examination and treatment. The Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health treatment and advice.

All nursing staff reported they would refer to the mental health liaison and rapid assessment, interface and discharge team and showed good understanding of when would be appropriate to do so.

The trust set a target of 80% for completion of mental capacity act training. From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 94.5% of all qualified nursing staff in urgent and emergency care compared to the trust target of 80%. However, compliance rate was lower for medical staff.

We looked at seven patient records and saw that capacity assessments and referrals to the rapid assessment interface and discharge team were not always completed.

A breakdown of compliance for mental capacity act level 2 training from December 2017 to December 2018 for qualified nursing and medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>69</td>
<td>73</td>
<td>94.5%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>18</td>
<td>24</td>
<td>75.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Qualified nursing staff in urgent and emergency care met the trust target of 80% with a completion rate of 94.5%.

Medical staff in urgent and emergency care did not meet the trust target of 80% with a
completion rate of 75.0%. It should be noted this staff group not meeting the target is due to only six eligible staff not having completed the training, so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
Is the service caring?

Compassionate care

Staff were mindful of the privacy and dignity of patients, they pulled curtains around cubicle areas when examining and discussing care with patients. This was seen in both the adults and childrens emergency areas. However, we saw that some adult patients were cared for in the corridor without screens which meant their privacy or dignity could not be maintained.

We saw most staff cared for patients with compassion and kindness and treated them well in the urgent and emergency department.

However, we saw pediatric staff in the childrens emergency department focused on the task rather than treating patients as individuals.

We saw receptionists welcoming new patients. Eight patients we spoke to in the waiting area described the staff as “lovely”, “very pleasant” and “easy to understand” and patients we spoke with in the adult emergency department were positive about the care they received. However, some parents we spoke to felt staff in the children’s emergency department were judgemental. Three parents told us they felt staff had been rude and abrupt. In contrast, the other four parents we spoke with said staff were pleasant and friendly.

The trust’s National Patient-led Assessment of the Care Environment (PLACE) assessment was carried out annually and the latest results were made available in November 2017. The trust had scored 84% for dignity and wellbeing an action plan was generated following the results.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than or like the England average in nine out of 12 months from November 2017 to October 2018.

There was improvement in the trust’s performance against this metric from March to May 2018 when performance was better than the England average. The trust’s performance peaked in May 2018 with 91.7% compared to the England average of 87.0%. Performance then dipped but recovered in October 2018.

In the most recent month, October 2018, the trust performance was 86.5% compared to the England average of 87.1%.

A&E Friends and Family Test performance - Tameside and Glossop Integrated Care NHS Foundation Trust
Emotional support

We saw staff reassuring patients and those close to them by listening to their concerns in the adult emergency areas.

Staff gave examples of working under emotionally demanding conditions during major incidents, offering emotional support to loved ones under difficult circumstances.

The hospital chaplains were available to offer spiritual care to patients of all faiths. The service was available 24 hours, seven days a week.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. We observed respectful, caring interactions between staff and patients with additional needs, staff offered encouragement to patients and were reassuring. However, this was not seen across the department. We found that the emotional needs of children and their parents were not always viewed as important, or reflected in their care, treatment and support.

Understanding and involvement of patients and those close to them

We spoke with 30 patients and those close to them who told us they were included in decisions made about their care and treatment.

During observations, we saw staff involve both patients and those close to them in their care and allowed time to answer any questions.

Patients we spoke to said they felt involved and were aware of their plan of care. Patients in the blue zone were particularly happy with the level of information they had received from the nurses and assistant practitioners.

Emergency Department Survey 2016
The trust scored about the same as other trusts for all the 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. 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>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Comparison</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Q38. 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>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. 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>4.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. 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>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall experience</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

Service delivery to meet the needs of local people

Most of the urgent and emergency care services were planned and delivered to meet the needs of the local population.

However, the children’s emergency department opened according to children’s nursing staffing availability, rather than to meet service needs. There was recognition that the number of children using the service was increasing and a business case to increase capacity was being developed. The report highlighted areas of improvements and had aligned these to Royal College of Children and Paediatric Health; facing the future standards (2015).

When the department was not open, children were initially seen in the main emergency department, but cared for in the paediatric area, if appropriate. However, on inspection we saw two occasions when children were waiting in the adult waiting area to be seen.

At the time of the inspection the service had identified there was no clearly pre-identified pathway for patients on a Section 136 order for an identified place of safety to meet their medical and mental health needs. However, the trust had an overarching ‘Place of Safety Policy’ which was available on the trust Intranet and had undergone a complete review in November 2018 and amendments made in April 2019. This policy included a flowchart with the patient’s pathway through the urgent and emergency care department and information on the management of patients who were under a section 136 order.

For children and young people, staff liaised with the children’s mental health services to identify a place of safety. The trust provided evidence to show that they had recognised this did not meet the standards of children in emergency care and were developing a standard operating procedure with a neighbouring mental health trust.

Security across the hospital was limited; three security guards were on shift at one time. Two guards patrolled the hospital whilst one manned the cameras. Staff felt that security did not always immediately attend to incidents in the emergency department because they were attending to another incident in the department. Staff we spoke with said the often-witnessed fights, abusive and aggressive patients.

The reception personnel and patients we spoke with, who had attended the department, said the seating in the main waiting area often became full and patients had to stand up, although we did not witness this during the inspection. We also found no reading material for those waiting in the main waiting area.

However, we saw systems were in place that effectively supported waiting times. Patients were streamed from the waiting area once they had been seen by the triage nurse, we saw patients being sent to emergency areas, the ambulatory care unit or the “blue zone” (care provided by emergency nurse practitioners.)

The trust worked collaboratively with local clinical commissioning group to review GP streaming and ensure that services across social and emergency care in the local area remained relevant and useful for the population being served.

The service was accessible and sign-posted from the main road with parking (including disabled parking) close by.

We saw that there was clear signage for different areas of the urgent and emergency department was which helped patients and visitors find their way around the department.
The paediatric waiting area was child friendly with wall decorations. When the area was opened it was separated from the main thoroughfare.

The service had links with the children and adolescents’ team, rapid response team and neighbouring hospitals including trauma centres and speciality hospitals to support patients using the service.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs always, including outside office hours and in an emergency.

For those waiting, the department offered refreshments to patients waiting, this included sandwiches, hot drinks and water. However, this was only offered in the adult department. Parents of children waiting for more than two hours were not offered any refreshments or food. Other drinks and snacks were available from vending machines situated upon entry to the department.

**Meeting people’s individual needs**

Visitors with hearing loss could access a hearing loop from the main reception, however information about how to access this was not displayed. We found that staff were unaware of how to access colleagues to use sign language.

We noted that information was not always accessible to all patients. For example, information leaflets on a range of conditions were available in the department, however they were not in another language and there was no information advising patients that they could be ordered in other languages if required.

We found no easy read documents for children and adults with learning disability. We asked four members of staff who said they did not have any tools apart from the basic communication folder to help patients understand their care and treatment. However, staff could access a learning disability checklist of areas to consider on the intranet.

There were no pictorial pain score tools to help patients with communication difficulties indicate pain levels. Instead staff were told to use their own experience and look for signs of distress when examining a patient to try to identify whether they were in pain. A range of books and toys were available to children in the paediatric waiting room. However, the department did not meet the standards of Royal College of Children and Paediatric Health; facing the future standards (2015) which stated children should have access to a play specialist. In the absence of the play specialist, no one provided distraction during procedures.

We found no booklets or books with pictures to aid staff with explaining pain and general assessment for children with or without a learning disability. During observation, we saw that some children were upset and not compliant with examinations and staff did not have any aids to help or comfort children.

Patients living with dementia were not clearly identified to help ensure staff were aware of their needs. Staff had access to distraction equipment to give to patients living with dementia. but memorabilia and activities for patients as a distraction whilst in the department was not available.

However, although we did not see any posters or leaflets informing staff or patients about ‘religious awareness in bereavement’. Staff we spoke with told us they would seek support from the chaplain service.
There was a relative’s room next door to the resuscitation area. This offered bereaved relatives a quiet room away from the department. The room contained drinks, comfortable sofas and leaflets regarding bereavement services.

For those whose first language was not English, staff could access interpreters using a recognised telephone translation service.

Staff and the care systems they followed, helped to provide care to patients in need of additional support. Leaflets regarding mental health were on display in the waiting areas. GP’s could refer directly to the Mental Health team at the department without patients going through triage.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all three questions relevant to the responsive domain in the emergency department survey 2016.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

Since the last inspection, the flow throughout the department had improved. The trust had introduced a number of initiatives to support patients accessing the service. These included extending the ambulance assessment area and the emergency nurse practitioner led blue zone. However, the trust still did not meet the Royal College of Emergency Medicine recommendation that states the time patients should wait from time of arrival to receiving treatment should be no more than one hour. This standard was not met over the 12-month period from November 2017 to October 2018.

The service streamed patients effectively to the right area for assessments.

The flow in the department was supported by having a wide number of services including, GP emergency and assessment services, ambulatory care unit and the advanced nurse practitioner led blue zone. Stable patients who had been referred by a GP were sent to the most appropriate area, but this was not always within 30 minutes of arrival. Despite having such interventions, the service did not meet the Department of Health’s target of 95% of patients admitted, transferred or discharged within four hours of arrival at the department, although the impact of the initiatives was having a positive effect and performance had improved and remained above 85% since March 2018.

Senior managers recognised the activity in the department was directly affected by bed capacity issues in the wider hospital, this was the primary reasons for any delays over four hours. The service
worked hard to keep delays to a minimum by maintaining flow not only in the department, but throughout the hospital. Within the department, a co-ordinator maintained an overview using information systems which colour coded patients depending upon the time spent in the department. The coordinator moved staff around the department depending upon where the delays were. For example, should ambulance patients start to queue, a second ‘floating’ nurse assisted by triaging patients.

Patients waiting for test results or requiring a short period of observation before going home were transferred from the department to the ambulatory emergency care unit to avoid overcrowding.

Triage/streaming staff assessed patient’s arriving by ambulance for suitability to be transferred to a chair to await treatment (“fit to sit” assessment). Only those patients who were well enough were given a chair instead of a stretcher. This helped the flow in the department.

The coordinator and department managers persistently monitored dashboards, they acted on increasing activities in the department to limit delays rather than waiting until patients breached the time in the department. We were told that actions included; finding medical staff from other specialities to review and select patients to admit to wards, coordinating discharge plans with discharge team to prepare patients for home and communicate effectively in capacity meetings to ensure the needs of the department were understood.

The service had appropriate discharge arrangements for people with complex health and social care needs. This included liaison with the local mental health trust.

The service had an effective full capacity protocol, escalation procedure consisted of four levels and required frequent monitoring. Capacity meetings were held several times daily depending upon the escalation level. When the escalation increased, so did the number of bed meetings.

**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 should be no more than one hour. The trust did not meet the standard over the 12 month period from November 2017 to October 2018.

From November 2017 to October 2018 performance against this standard was worse than the England average although showed an improving trend. Over the same time period, performance against this standard ranged from 80 minutes (May 2018) to 115 minutes (February 2018).

In the most recent month, October 2018, the median time to treatment was 90 minutes compared to the England average of 58 minutes.

**Median time from arrival to treatment from November 2017 to October 2018 at Tameside and Glossop Integrated Care NHS Foundation Trust**
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 emergency department.

From December 2017 to November 2018 the trust met the standard in two out of the 12 months (May and August 2018). Over the same period, the trust performed better than or the same as the England average with the exception of one month (February 2018).

From December 2017 to November 2018, the trust's performance against this metric showed a similar pattern to the England average.

From December 2017 to February 2018, performance deteriorated but as this may be because it was over the winter months. Performance then improved and has remained above 85.0% since March 2018.

Four hour target performance - Tameside and Glossop Integrated Care NHS Foundation Trust

(Source: NHS England - A&E Waiting times)
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From December 2017 to November 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average with the exceptions of January to April 2018, when it was worse.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Tameside and Glossop Integrated Care NHS Foundation Trust**

![Graph showing percentage of patients waiting more than four hours from decision to admit until being admitted]

The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted by month over this time period:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>271</td>
</tr>
<tr>
<td>January 2018</td>
<td>622</td>
</tr>
<tr>
<td>February 2018</td>
<td>530</td>
</tr>
<tr>
<td>March 2018</td>
<td>452</td>
</tr>
<tr>
<td>April 2018</td>
<td>349</td>
</tr>
<tr>
<td>May 2018</td>
<td>71</td>
</tr>
<tr>
<td>June 2018</td>
<td>99</td>
</tr>
<tr>
<td>July 2018</td>
<td>114</td>
</tr>
<tr>
<td>August 2018</td>
<td>80</td>
</tr>
<tr>
<td>September 2018</td>
<td>147</td>
</tr>
<tr>
<td>October 2018</td>
<td>67</td>
</tr>
<tr>
<td>November 2018</td>
<td>97</td>
</tr>
</tbody>
</table>

The highest numbers of patients waiting over four hours were in January 2018 (622) and February 2018 (530).

(Source: NHS England - A&E SitReps)
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from December 2017 to November 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

(Source: NHS England - A&E Waiting times)

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

From November 2017 to October 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average in seven of the 12 months and worse than the England average in five of the 12 months.

The percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment has been 0% since May 2018.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Tameside and Glossop Integrated Care NHS Foundation Trust

![](chart.png)

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From December 2017 to November 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average.

In February 2018 the trust’s monthly median total time in A&E for all patients was 218 minutes compared to the England average of 156 minutes.

In the latest month, October 2018, the trust’s monthly median total time in A&E for all patients
was 191 minutes compared to the England average of 151 minutes.

**Median total time in A&E per patient - Tameside and Glossop Integrated Care NHS Foundation Trust**

![Graph showing comparison between This Trust and England Avg. median total time in A&E per patient from Nov-17 to Oct-18.](chart)

(Source: NHS Digital - A&E quality indicators)

**Learning from complaints and concerns**

The services had a system in place to ensure complaints and compliments were listened to with a view to improving services for patients.

Staff told us they would look to resolve a concern informally first, but complaints were dealt with formally if necessary. We saw that governance arrangements in place ensured that lessons from complaints were shared amongst staff. We saw evidence of this in four complaints we reviewed from the paediatric and the adult urgent and emergency department.

We saw leaflets in the waiting area and posters displayed within the services showing how to complain. Literature signposted patients or their carers or relatives to the trust’s patient advice and liaison services (PALS) for support in making a complaint.

The leadership team were keen to address any learning from complaints and tried to improve the service as a result. For example, in response to a complaint, a memo was sent to all doctors to remind them of the importance of recording specific information on a prescription.

The service investigated all complaints raised. The approach was determined through a daily triage process, undertaken by the PALS service. All four complaints we reviewed had been reviewed by senior managers and where necessary staff were asked for reflections.

The trust acknowledged complaints formally within 3 working days and aimed to resolve complaints as quickly as possible, but as a maximum within 45 working days, to allow time for a thorough and robust investigation to be undertaken alongside the existing clinical commitments of staff.
Summary of complaints

From December 2017 to November 2018 the trust received 102 complaints in relation to urgent and emergency care (23.6% of total complaints received by the trust). The main subject of complaints was clinical treatment (53).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>53</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>13</td>
</tr>
<tr>
<td>Communications</td>
<td>13</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>9</td>
</tr>
<tr>
<td>Patient Care</td>
<td>6</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>1</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Admin/policies/procedures (including patient record)</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

For the 87 complaints that had been closed at the time of data submission, the trust took an average of 39.1 working days to investigate and close these. This is in line with their complaints policy, which states complaints should be closed within 45 working days.

The 15 complaints that had not yet been closed had been open for an average of 21.7 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Is the service well-led?

Leadership

The leadership team for urgent and emergency was made up of a multidisciplinary team which had clinical and business management expertise. The leadership team reported to the hospital management board.

The leadership team had experience in commissioning, designing and running their services. It was evident from discussions that their priority was to run a clinically safe service whilst promoting the delivery of high-quality person-centred care.

Staff told us their leadership team was approachable and visible and the team told us that they met regularly in different forums to discuss quality, finances and governance. Site level meetings rotate so the team were visible.

The leadership team derived support from senior sisters with whom they met regularly at sisters’ forums.

Vision and strategy

There was a clear statement of vision which was driven by quality and sustainability. The service used the trust’s vision, which was to ‘improve health outcomes for the population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and health and care partners.

The vision was underpinned by the five-year strategic plan, which outlined the commitment to supporting the workforce through ongoing transformation. The trust had a local workforce transformation group to looked at developing the workforce plan which covered training and development.

Senior managers we spoke with said the quality improvement plan was incorporated within the strategy; this focused on the flow of the department in the department. We saw that the vision and values were embedded through induction and appraisal.

Board meetings we looked at showed evidence of senior managers reviewing the progress of the urgent and emergency strategy

The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. Senior staff from both the trust and the local mental health trust met to discuss operations and strategy.

Culture

We observed staff across the services we visited had a positive culture and were proud to provide patient focussed care to patients.

Staff we spoke with described good teamwork and multi-disciplinary working with visible leaders who were happy to help and provide support.

Staff had various forums in which they could express their views and be heard including one to ones, team meetings, and safety huddles.

Staff told us the trust awarded employees’ for going over and beyond. Staff could be nominated by colleagues and patients for the award.

Governance
We saw that the service had a clear governance framework with staff assigned to specific roles that ensured quality performance and risks were known about and managed appropriately.

The leadership team met regularly in different forums to discuss the local governance. For example, there were weekly directorate management meetings, which fed into the monthly divisional meetings, plus monthly directors’ meetings. Consultants within the specialities took part in the monthly clinical effectiveness meetings. This was followed by a monthly business meeting at a local level.

We saw minutes for the clinical governance meeting. The trust had introduced a standard template which looked at: NICE guidance, a patient story, incident review/trend analysis, monitoring of action plans, review of the risk register, patient feedback, clinical effectiveness, audit, and any other business.

Senior matrons met as a group and discussed governance issues including learning from incidents or complaints and staffing issues together with issues cascaded to them from the leadership team.

The Infection Prevention Group aligned to the Patient Safety Programme Board reported to Service Quality and Operational Governance Group. Information including hand hygiene, incidents and falls were discussed.

**Management of risk, issues and performance**

The leadership team received information to support them in managing risk, identifying issues, and assessing performance.

We spoke with the leadership team about how they measured quality and performance. The team had access to various sources of information, such as department metrics, which captured a series of indicators ranging from audits to safety performance figures. This information was examined, discussed and action taken through a range of senior leadership meetings.

We discussed with the leadership team the risk register. Risk registers were maintained at site level and department risks were noted, with a brief description of the risk, control measures, an owner, risk level and a review date.

Systems were in place to ensure operational pressures were escalated appropriately. The trust used the Operational Pressures Escalation Levels framework by NHS England to monitor the level of risk and associated actions required to manage capacity within the hospital.

Performance against targets and flow issues were monitored throughout the day. A dedicated staff member manned an escalation phone where delays could be logged ready for discussion in one of several daily bed meetings.

We spoke to the leadership team about their risks, they were familiar with their risks and explained how they were mitigating them. For example, high medical staffing vacancy rate was noted as a risk on the register. Members of the senior leadership team we spoke with told us that they were actively looking at different recruitment incentives to sustain staffing levels and had introduced development pathways for the role of the advanced nurse practitioner.

Measures and information relating to quality and safety was provided at department level to the leadership team. We saw examples of the performance summaries the leadership team had access to.

Risks to staff were also managed, for example, glass screens in the reception areas, meant staff were safe. However, there was not always a security presence in the department. Staff we spoke with said when patients become violent and aggressive, they had called the police because security guards were not always close by.
Information management

An integrated reporting system supported effective decision making in the emergency department. The electronic dashboard was visible in main areas of the department, within this was incorporated a workload predictor which displayed a graph of the anticipated number of patients based on previous years. This system provided staff with details about the number of patients in the department, how long they had been there and whether there was a plan in place for them. It also forecasted the departments workload.

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

From speaking with staff and reviewing information supplied in electronic format, it was clear that staff at all levels could access information in a digital format which could be interpreted and rapidly used to help improve the service.

We saw that urgent and emergency care meetings evidenced staff discussed quality performance and sustainability regularly. We saw that staff had access to information and were confident to challenge the data.

The leadership team received regular reports on all aspects of performance based on various documents, such as the trust’s board assurance framework (BAF), comprehensive risk register. In addition, the trust ran a series of sub-board scrutiny committees where information was shared.

Staff had sight of clinical governance reports with real time dashboards, so that information about the department could be reviewed openly by staff at all levels.

In the staff room, we saw that information was displayed for staff to review which included information about incidents, complaints, compliments and feedback and projects to get involved with. A specific noticeboard was available for students working in the department.

Engagement

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

Senior nurses described different forums which enabled managers to capture views of staff and the public. Additionally, shared learning and general information was disseminated through these forums. Minutes from the forums demonstrated a sense of shared responsibility and engagement with staff about ideas to improve services.

Staff were praised for good practice; we saw that managers had issued certificate of achievement to those who were nominated.

Monthly newsletters concentrated on different themes that had emerged the previous month from observations, incidents, complaints and best practice stories. For example, issue two of 2019 newsletter focused on poor waste management practices and the article listed the risks and the associated costs. It also celebrated achievements in the department and named staff members for team work.

We saw some examples of engagement with patients and the public. The Friends and Family test was well established. Whilst response rates over the previous year had not risen above 27%, the results were generally favourable with an average of 90% of people recommending the service to friends or family members.
Learning, continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels of the service. The service was keen to act on and improve services by learning from when things go well and when they go wrong.

Previously the service did not have a coordinator in the department, which lead the team at departmental level. This meant previously there was no oversight of the movement of patients across the department. Since the last inspection the service had introduced a department coordinator that ensured the floor was managed appropriately. The role included looking at the flow of the department, black breaches, ambulance waits, bed allocations and escalations. All staff we spoke with said the department ran better with the coordinator in place.

We saw evidence of service reviews by internal teams as well as independent reviews to identify areas of improvement and make the required changes. For example, a review of the department layout found that it did not meet the needs of patients and the service. Since the last inspection the trust changed the location of the relative’s room, so it is now situated next to the resuscitation area and expanded the ambulance triage area so that it housed four bays to improve the flow in the department.

The service had implemented a streaming programme; the programme was supported by a multidisciplinary team and applied to the ambulatory care unit, integrated assessment unit, the associated nurse practitioner led blue zone and the adult and paediatric urgent and emergency department. Co-locating doctors and practitioners from a range of specialties helped maintain flow.

Innovative ‘virtual’ clinics were being held regularly to minimise overnight stays and increase flow through the department and wider hospital.

The digital health service initiative reduced the number of unnecessary urgent and emergency department admissions. The service offered professionals from care homes an option to ‘skype’ call a health and social care professional to prevent residents coming into hospital. Staff told us this had impacted the urgent and emergency service because it had decreased the number of unnecessary attendances to the emergency department.

The department also engaged with the ambulance service to pilot a scheme that provide support and management for patients who called 999 but were categorised by the ambulance provider as a Category 3 or 4 (which means cases were not immediately life threatening). The digital health team went out to visit category 3 and 4 calls patients, in a car provided by ambulance provider, to ‘see and treat’ patients wherever possible preventing the need for an ambulance and an A&E attendance.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at Tameside and Glossop Integrated Care NHS Foundation Trust provides care and treatment for a number of specialties at one acute site, Tameside General Hospital. There are 292 medical inpatient beds located across 11 wards.

The service provided is a consultant led service supported by multi-disciplinary teams to provide inpatient care for the local population. This care covers the breadth of medical specialties, with the majority provided by a locally employed team, these are:

- General medicine
- Cardiology
- Respiratory
- Geriatric medicine
- Gastroenterology
- Stroke
- Diabetes & endocrinology
- Rheumatology
- Dermatology
- Haematology
- Clinical oncology

Where specialist tertiary expertise is required or for smaller medical specialties, service agreements are in place with NHS providers.

(Source: Universal Routine Provider Information Request (RPIR) – Sites tab / Routine Provider Information Request AC1 – Context acute tab)

The trust had 25,312 medical admissions from August 2017 to July 2018. Emergency admissions accounted for 17,112 (67.6%), 145 (0.6%) were elective, and the remaining 8,055 (31.8%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 15,882 admissions
- Gastroenterology: 5,235 admissions
- Geriatric medicine: 1,229 admissions

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Ward managers received the training matrix every month so that they knew which staff had completed mandatory training. Pay increments were dependent on staff completing mandatory training. If staff completed mandatory training in their own time they would get this time back. Staff could put an app on their phone so they could do their online training at home.

Volunteers could access appropriate mandatory training.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling level 1</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>206</td>
<td>211</td>
<td>97.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>202</td>
<td>211</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>198</td>
<td>211</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>195</td>
<td>211</td>
<td>92.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>194</td>
<td>211</td>
<td>91.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>182</td>
<td>206</td>
<td>88.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The completion rate for basic life support training was 80.1% and for intermediate life support training was 86.7%

In medical care the trust had an overall mandatory training compliance rate of 93.4% for qualified nursing staff. The 95% target was met for three of the seven mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff</th>
<th>Number of eligible</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 70
In medical care the trust had an overall mandatory training compliance rate of 83% for medical staff. The 95% target was met for one of the seven mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff knew how to protect patients from abuse and the service worked with other agencies to do so, staff had received training on how to recognise and report abuse and were able to give examples of when they had done this.

On the acute medical unit any patient with a safeguarding issue was identified on the white board and these patients were discussed at the daily huddles. There were senior safeguarding managers on duty every day who were identified on a board so that staff knew at a glance who the safeguarding manager of the day was.

At the board meetings there was discussion about patients who had safeguarding issues. There was an “enacting a safeguarding adults concern and enquiry checklist” for the patient record. This showed where any safeguarding processes were up to at a glance without having to go through at the patient record. There were also stickers for the patient record. Staff said that this was extremely useful. We saw during the inspection that the checklists had been completed by staff.

All staff we spoke with said that they got good support from the safeguarding team and they were responsive to any enquiries.

On ward 41 (dementia/older people) there was a safeguarding board for staff and patients. There were explanations about the different types of abuse and details about safeguarding managers including details of safeguarding managers available out of hours. There was a flowchart of what to do if a safeguarding issue was identified. Information was available about Prevent which is safeguarding people and communities against the threat of terrorism and information about modern slavery.

Staff gave us examples of safeguarding incidents and the actions that they had taken. There were safeguarding champions for each bay so that staff knew that patients in that bay and patients liked the continuity of the same staff members.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules from December 2017 to December 2018 for qualified nursing staff in medical care is shown below:

| Module                        | Trained (YTD) | Staff (YTD) | Compliance Rate (YTD) | Target | Pass  
|-------------------------------|---------------|-------------|------------------------|--------|-------
| Manual handling level 1      | 1             | 1           | 100.0%                 | 95.0%  | Yes   
| Fire safety                  | 52            | 57          | 91.2%                  | 95.0%  | No    
| Infection prevention         | 48            | 57          | 84.2%                  | 95.0%  | No    
| Health and safety            | 48            | 57          | 84.2%                  | 95.0%  | No    
| Equality and diversity       | 46            | 57          | 80.7%                  | 95.0%  | No    
| Information governance       | 45            | 57          | 78.9%                  | 95.0%  | No    
| Manual handling level 2      | 44            | 56          | 78.6%                  | 95.0%  | No    

20171116 900885 Post-inspection Evidence appendix template v3
In medical care the trust had an overall safeguarding training compliance rate of 97.2% for qualified nursing staff. The 95% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible.

It should be noted that for the one safeguarding module not meeting the target, this is due to only one eligible staff not having completed the training so the performance should be taken in context when dealing with low numbers of eligible staff.

A breakdown of compliance for safeguarding training modules from December 2017 to December 2018 for medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>208</td>
<td>211</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>201</td>
<td>209</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medical care the trust had an overall safeguarding training compliance rate of 87.7% for medical staff. The 95% target was met for two of the four safeguarding training modules for which medical staff were eligible.

It should be noted that the two safeguarding modules with a completion rate of 100.0% relate to only one eligible staff so the performance should be taken in context when dealing with low numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Equipment and premises were kept clean and there were systems and processes in place to prevent the spread of infection.

The trust had carried out a project to improve patient hand hygiene to reduce health care related infections in the hospital setting and this had been trialled on three medical wards over a month. In all the wards there was a programme for the reduction of gram negative blood stream infections. Once infections were reduced, wards worked to continue the changes implemented and none of the wards had health care associated Clostridium difficile infections in the six months after the trial had taken place.
The acute medical unit was visibly clean and tidy. There was personal, protective equipment available for all staff and we saw that it was used appropriately. Handgel was available in all clinical and ward areas for staff, patients and visitors.

Patients with known infections were discussed at the board meetings and the type of infection would indicate what type of cleaning was required for their rooms and any equipment that had been used. During the inspection we saw that a number of patients were housed in side rooms if they had symptoms of infection.

On ward 45 we saw a completed cleaning schedule at the ward entrance; the ward was visibly clean and tidy.

On ward 41 there was an infection control board with information for patients about hand hygiene and information about Clostridium difficile and its symptoms. There was a process chart which identified items that needed to be cleaned and who was responsible for the cleaning. On the audit board for the week commencing 11 March hand hygiene scores were at 100% and commode cleaning was at 100%. There were posters reminding staff about uniform policy and hand hygiene.

The endoscopy unit was visibly clean, tidy and well organised. Personal protective equipment was available for staff and we saw that they used it. There were visors, goggles, arm protectors and visors available to protect staff who worked in the decontamination areas to protect them from infection and splashes from chemicals.

The endoscopy unit cleaned and decontaminated all the scopes used at the hospital. We saw that processes were in place and scopes were taken from the endoscopy rooms at the end of treatment to be cleaned, decontaminated and dried. The staff showed how they ensured the traceability of each scope from the doctor or nurse who carried out the procedure, the patient who had the procedure and the staff who decontaminated and cleaned each scope.

Patients were asked if they had ever been notified that they were at increased risk of Creutzfeldt-Jakob disease (CJD) or variant Creutzfeldt–Jakob disease (vCJD). If any scope was used on a patient with CJD or vCJD it would be immediately withdrawn from use and destroyed. The traceability of the scopes enabled the service to trace patients who had been exposed to that particular scope.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The senior team told us that there had been a lot of work done to improve the environment on a number of wards and that they were proud of this work. Most of the wards we visited were spacious, light and airy and there was plenty of space between the beds. There were spacious areas in the ward entrances that some wards were developing into spaces that patients could use. On one ward the ward manager was considering removing the nurses station to make a rehabilitation area for patients.

We saw that there were colour coded bags and bins for the appropriate disposal of clinical waste. There were posters around the hospital to show what type of waste went into which bin.

On the acute medical unit there were two resuscitation trollies that were checked every day; we saw documentation to confirm this. There was also a weekly check. The trollies were checked by the clinical facilitors who also checked the defibrillator and the oxygen cylinders.

There were a number of procedure trollies which were fully stocked for procedures that could be carried out on the AMU including tracheostomies, lumbar punctures and chest drains. These were
checked daily by the clinical facilitators. There was a sepsis box for the timely treatment of sepsis when it was identified.

There were three housekeepers on the AMU who kept the unit clean and tidy and were responsible for ordering and replenishing stock; staff said that they were invaluable to the running of the ward.

On the acute cardiology ward, there was telemetry available at each patient bed so that patients cardiac status could be monitored from a screen at the nurses station. We saw that the resuscitation trolley was checked daily and that this was documented.

On ward 45 we saw that the staff did mattress checks and that these had been completed and were documented. Thermometers had been serviced and checked and the two heart rate monitors had been serviced. The heart rate monitors were checked every day and we saw documentation that supported this. The resuscitation trolley was checked daily and a more comprehensive check was done every week. The trolley contained a guide of what should be checked daily and weekly.

On ward 40 the resuscitation trolleys had been checked and this was documented; we checked the contents which were in date. There were also a sepsis box kept on the trolley.

There was a managed equipment contract for scopes in the endoscopy unit so that any faulty scope was replaced in 24 hours. The unit had purchased a three dimensional imager to improve patient comfort and to support training for staff.

**Assessing and responding to patient risk**

There were systems and processes in place to manage patient risk. Senior managers at the hospital were aware of patient safety risk through regular reporting structures.

Patients were triaged on arrival on the acute medical unit, which included information about the patients age, diagnosis, pending investigations, social circumstances and any infection control risk. Patients had their frailty score calculated using the Rockwood clinical frailty scale. These scores were recorded on the white board and staff told us that this helped to determine the acuity of the patient. Patients with acute kidney injury were also identified on the whiteboard.

There were two clinical practitioners on the acute medical unit who had experience of working in critical care. They were responsible for the risk assessment of all patients on the unit and the identification of the deteriorating patients. Every patient was risk assessed daily to identify the patients who were the most poorly. This information was fed into the early board round meeting. If they had concerns about patients they would contact the critical care outreach team. Feedback from the critical care outreach team was that appropriate patients were referred for assessment in a timely manner and that the number of patients who had to go to the critical care unit had reduced.

The unit used the national early warning scores (NEWS) to identify deteriorating patients, staff had undertaken training for NEWS 2 which is the latest version of NEWS. This was completed online. We saw that competencies had been signed off for the NEWS training. Staff had also received training on the sepsis 6 bundle for the identification and management of sepsis. Audit information showed that 100% of appropriate patients who arrived on the unit had NEWS completed and a sepsis check.

There was an arterial blood gas machine on the acute medical unit to assist staff in the diagnosis of conditions such as sepsis and acute kidney injury. There was also an aide memoire for staff.
dealing with patients with spinal cord compression which had been developed by the clinical facilitators.

Staff used the nurse delirium screening scale for patients with a possible diagnosis of delirium.

Wherever possible, patients were never moved from the acute medical unit until they had been reviewed by a consultant; this was one of the key performance indicators for the service.

The most poorly patients were placed in beds visible from the nurses station on the acute cardiology ward.

We saw that a number of patients across the medical wards were on one to one observations to keep them safe. On the dementia care wards, there was usually a member of staff present in each bay at all times to reduce the risk of harm to patients. We observed a patient who was on ward 42 who was at high risk of falls was on one to one observations, 24 hours a day and was in a low rise bed.

On ward 45, staff used an acuity or dependency tool to identify patients with the most complex needs, this was discussed at the safety huddle at 07.30 am. The tool identified those patients with the potential to deteriorate, those who were on normal ward care, those who were stable but dependant on full nursing care and those who required expert staff and a dedicated bed. There was a patient board which identified any patient at risk, the board had information about risk assessments and we saw that apart from one patient all patients had a venous thromboembolism assessment completed. The board highlighted anybody at risk of falls, patients with dementia and cognitive impairment and patients who were subject to a Deprivation of Liberty Safeguards order. The board also showed nutritional status and length of stay with estimated discharge date.

On ward 42 (gastrology), there was a morning handover of care at 7.00am followed by a safety huddle at 7.30am. Any risks were discussed at this meeting and these were updated on the patient white board. The care co-ordinator updated the board and supported discharge planning.

On ward 41 (dementia and older people) high risk patients were placed near the nurses station for observation. In the daytime the ward tried to keep a member of staff on each bay at all times and at night they based staff outside the bays. The ward manager said that this had reduced falls on the ward.

On ward 40, we saw that staff used an acuity or dependency tool to identify patients with the most complex needs. Patients were monitored using the NEWS system. We checked one patient’s record who triggered on the early warning score. This was appropriately recorded and escalated. There was a record that the patient had been reviewed by medical staff.

There was close circuit television at the entrance to each ward so that staff could see who was coming onto the ward, people entering the ward used as buzzer to alert staff of their presence. Patients who had received sedation in the endoscopy unit had to wait at least 40 minutes in the recovery area before they could leave the department. There were discharge criteria for patients.

Nurse staffing

The service had mostly enough staff including doctors and nurses with the right skills, experience and training to keep people safe from avoidable harm and provide the right care and treatment.

The trust had done some work on the nursing establishment of the wards and to review skill mix dependant on the acuity of the patients. For example on one ward a sister had been appointed on permanent nights; the role was a teaching role to help to support the existing night staff.
The ward manager of the acute medical unit told us that there were always seven qualified staff on the unit which was an appropriate number of nurses for the unit. The unit could use bank and agency staff if necessary and these were often existing staff from the unit doing additional shifts. There were some band five vacancies but these had been recruited to. There was a shift co-ordinator who co-ordinated the flow of patients through the unit who was supernumery to the staffing numbers.

On the acute cardiology unit one of the nurses told us that there were just adequate staff to meet the needs of the patients. There should have been three qualified nurses on the ward but due to sickness there were only two. One of the specialist nurses was covering so that there were enough staff on the shift. There were two non-qualified staff on the shift.

Staff told us that the ward staffing was dependant on the acuity of the patients on the ward and the competencies of the staff so that although there might be three qualified staff on the ward not all of the staff might have all the competencies needed for the acuity of the patients. There was ongoing competency training for all staff on the ward.

On ward 45, the stroke rehabilitation ward, we saw that planned and actual staffing was achieved. There were three qualified staff on the early shifts and two on the late shift and the night shift. There were five unqualified staff on the early shift and four on the late shift and night shift. The ward manager told us that they could request additional unqualified staff if necessary. There was also a co-ordinator who was supernumery to the staffing numbers and the ward had a housekeeper. When we spoke with staff they told us that the staffing numbers were not always appropriate if the levels of patient acuity were high, eg if patients required intravenous therapy, naso-gastric feeding and sometimes it took longer to get round all the patients. Patients were also supported by physiotherapists and occupational therapists during the day and there were activities on the ward to support patient rehabilitation.

On ward 42 (gastrology) the ward manager said that they were not fully staffed with qualified staff but fully staffed with non-qualified staff. The ward had been trialing the use of a pharmacy technician to do the medicine rounds. The ward manager said that this had been successful and that they wanted it to continue. It freed up nursing staff and the pharmacy technician was enjoying the patient contact.

On ward 41 (dementia and older peoples care), the ward was fully staffed at the time of the inspection. The ward manager said that the staffing of the ward was adequate and that sometimes they had an extra health care assistant at night to support staff. There was a supernumery co-ordinator who co-ordinated discharge for patients. The ward manager said that this had helped staffing on the ward as nurses could get on with what they needed to do.

On ward 40 (respiratory ward) staffing was managed according to acuity and dependency of the patients. This information was updated daily and was monitored by matron who did a daily walkaround the ward. There was support to have additional staff, when needed, to meet the acuity of the patients, but we were told it was sometimes difficult to find suitable staff to fill the shifts.

There was active recruitment to vacant posts with new starters due to start in April and July.

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There was active recruitment to vacant posts with new starters due to start in April and July.

The ward was a designated area of the hospital that cared for patients receiving non-invasive ventilation. The staffing levels on the ward did not meet the recommendation from the British Thoracic Society and Intensive Care Society guidance (2016). The guidance states that staffing levels should be above that of a general medical ward with one nurse for every two patients receiving non-invasive ventilation especially during the first 24 hours of treatment. The planned staffing level on the ward was three registered nurses, four health care assistants and a ward manager during the day and three registered nurses and three health care assistants during the...
night for up to 30 patients. We reviewed nine days of staffing and acuity levels. On seven out of
the nine days, there were at two or more patients who were identified as level two (requiring 8.6
care hours per day). The staff on the ward confirmed that level two patients were those on non-
invasive ventilation. This meant if one nurse was caring for two patients, the staffing level for the
remaining patients was two registered nurses for up to 28 patients. The ward manager frequently
delivered care as part of the team which meant there were three registered nurses for 28 patients.

The planned level of registered nurses was met on all the shifts reviewed. An incident form
regarding staffing levels was completed once during the nine days. The management team were
aware of the staffing challenges and were considering a number of options to improve the staffing
levels on the ward.

The ward manager on the endoscopy unit told us that staffing was good, there was a vacancy for
a band two member of staff and a band five was starting the week of the inspection. They told us
that they did not have any problems recruiting staff and that retention of staff on the unit was good,
with may staff having worked there for many years. There had been considerable interest in the
band two post when it went out to advert.

The trust reported the following qualified nursing staff numbers for the two periods below for
medical care:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>225.5</td>
<td>274.7</td>
</tr>
</tbody>
</table>

The trust reported a qualified nursing staffing level of 82.1% in medical care from April 2017 to
March 2018. This increased to 83.3% from April to November 2018.

From April to November 2018, there were 45.1 fewer WTE staff in post than planned for and 0.1
less WTE staff in post than from April 2017 to March 2018. There was a decrease of 4.2 WTE
planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From December 2017 to November 2018 the trust reported an overall vacancy rate of 18.0% for
qualified nursing staff in medical care. This was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 12.7% for qualified
nursing staff in medical care. This was higher than the trust target of 12%.

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

Sickness rates
From November 2017 to October 2018, the trust reported a sickness rate of 5.4% for qualified nursing staff in medical care. This was higher than the trust target of 4.2%.

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

Bank and agency staff usage

From December 2017 to November 2018 the trust reported 140,077.2 of the 839,943.0 available hours were filled by bank staff (16.7%) and 48,475.3 hours were filled by agency staff (5.8%) in medical care. There were 249,947.2 hours that needed to be covered by bank or agency staff but were left unfilled (29.8%).

None of the non-qualified nursing hours were filled by agency staff. The trust gave the reason of 'vacancies' for the usage of bank and agency staff

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Qualified</td>
<td>37,398.1</td>
</tr>
<tr>
<td>Non-qualified</td>
<td>102,679.1</td>
</tr>
<tr>
<td>Total</td>
<td>140,077.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

There were five consultants who worked on the acute medical unit and there was consultant coverage during the weekend. They were supported by other staff including registrars and junior doctors. There were daily consultant meetings at 8.30 am with doctors from urgent and emergency (U and E) care and staff from the medicine directorate. Doctors were aware of overnight U and E pressures and where beds were needed in different specialities to move patients from the urgent and emergency department.

There were two consultant teams on the acute cardiology ward who were working with junior staff and nursing teams.

On ward 40, medical staff said that, although there were some gaps in rotas, these were managed and the consultants visited daily and supported junior staff.

Consultant cover for night time and weekend was a consultant resident on call Monday to Friday 5pm to 9pm, consultant cover from 9.00am to 13.00pm and 18.00pm to 20.00 pm on a Saturday and Sunday 8.00am to 10.00am. For the remainder of the time the consultant is non-resident on call. The registrars were resident on call 24 hours a day seven days a week.

The trust reported the following medical staff numbers for the two periods below for medical care:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
</tbody>
</table>

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The trust reported a staffing level of 65.9% for medical staff in medical care from April 2017 to March 2018. This increased to 73.8% from April to November 2018.

From April to November 2018, there were 26.4 fewer WTE staff in post than planned for and 12.1 more WTE staff in post than from April 2017 to March 2018. There was an increase of 6.4 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From December 2017 to November 2018 the trust reported an overall vacancy rate of 32.7% for medical staff in medical care. This was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 4.0% for medical staff in medical care. This was lower than the trust target of 12%.

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

From November 2017 to October 2018, the trust reported a sickness rate of 1.4% for medical staff in medical care. This was lower than the trust target of 4.2%.

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

From November 2017 to October 2018 the trust reported 12,881.9 of the 222,554.4 available medical staff hours were filled by bank staff (5.8%) and 22,098.4 hours were filled by locum staff (9.9%) in medical care. In addition, there were 34,981.0 hours that needed to be covered by bank or locum staff but were left unfilled (15.7%).

The trust gave the reason of ‘vacancies’ for the usage of bank and locum staff.

A breakdown of bank and locum usage is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Tameside General Hospital</td>
<td>12,881.9</td>
</tr>
<tr>
<td></td>
<td>5.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)
Staffing skill mix

In September 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 72 whole time equivalent staff working in medicine at Tameside and Glossop Integrated Care NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>16%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2


Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. They were stored securely.

Records were paper records and were generally well structured and in good order with no loose sheets. On the acute cardiology ward we looked at two nursing records. We saw that allergies were recorded and safeguarding concerns were documented with the appropriate check list completed. Risk assessments had been completed including falls risk assessments and their were review dates on the risk assessments which were reviewed every seven days. Pressure ulcer prevention and Waterlow scores were also recorded. Records were legible and were signed and dated. We looked at a medical record and saw that this had been completed and was signed and dated and was legible. On the cardiology unit, records were stored in the doctors room which was accessible with a keypad.

On ward 45 records were kept behind the main reception area in cabinets that were not locked, there was however secure access to the ward. We looked at a record and saw that all safeguarding documentation had been completed including a strategy meeting template. Risk assessments and pain assessments had been completed.

On ward 41 we looked at two patient records. One of the records included a care plan with nursing outcomes and a completed mental health assessment. Risk assessments were completed and reviewed and pain charts and the malnutrition universal scores had been completed. The care plan described how the patient required emotional support and how communication needed to be maintained. The rehabilitation goals had been completed and the patient was ready for discharge to the Stanford unit for further rehabilitation. The second patient record was well completed with
documentation for mental capacity and Deprivation of Liberty Safeguards, there was an easy read version in the patient file. There was a bed rails risk assessment and it was noted that the patient was unable to use a call bell. Measures were in place to address this. Risk assessments had been completed and early warning scores documented. The records were well organised and there were no loose sheets in the file. All entries were signed and dated.

On ward 40 we reviewed three sets of records. All entries dated, timed, signed. Staff reported that the staffing levels sometimes impacted on the standard of record-keeping. One patient had been admitted to the ward over 36 hours earlier. They had been assessed, but there were no written nursing care plans in place. This was raised with the ward manager at the time.

Patient records in the endoscopy unit were stored securely in a room behind the nurses station. The unit had its own documentation which was the endoscopy nursing care plan. This included pre procedure admission details, the World Health Organisation checklist, peri-procedure details and post procedure and discharge details.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicines at the right dose at the right time.

Medicines, including intravenous fluids, were stored securely and access was restricted to authorised staff.

Medicines and equipment for use in a medical emergency were readily available and regular checks were completed to ensure they were present and in-date.

Controlled drugs were stored securely, appropriate records were maintained, and regular balance checks were carried out. However, nursing staff did not have the means to measure liquid controlled drugs accurately when performing balance checks. We raised this with the trust who gave us assurance that a new procedure, supported by an updated policy, was being implemented in April 2019 to improve the management of liquid controlled drugs.

Pharmacists checked (reconciled) patients’ medicines on admission to hospital and this generally occurred in a timely manner. However, when patients were admitted over the weekend, we saw the medicines reconciliation process was not always completed within 24 hours. Where discrepancies were identified, systems were in place to ensure these were followed-up.

The trust had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of antimicrobial resistance. For example, there were two antimicrobial pharmacists in post who attended multidisciplinary ward rounds and reviewed individual patients. Indications and stop dates were routinely recorded when antibiotics were prescribed, and prescriptions were regularly reviewed to ensure they remained appropriate.

When patients were admitted to hospital, medical staff completed venous thromboembolism (blood clots) risk assessments, which were included in the medicines charts. Patients had been prescribed appropriate prophylaxis for venous thromboembolism where this was indicated. Oxygen was prescribed in line with legal and good practice requirements, and patients received regular review of their oxygen therapy.

The trust had taken steps to improve the timely supply of medicines, for example having a dedicated pharmacist and a satellite pharmacy for discharge prescriptions. In addition, a pilot of medicines being administered by a pharmacy technician had shown improvements in timeliness and safety on Ward 42.
**Incidents**

The service managed patient safety incidents well, staff knew how to report incidents and these were investigated by managers and lessons learned were shared with staff. Changes were made following incidents to improve patient care.

There was a “heat map” for inpatient ward areas. This provided information about staffing, compliments, complaints, moderate harm incidents, falls with harm, infections and pressure ulcers. The chart was RAG rated to indicate issues of performance.

There was an electronic incident form and on ward 42 the ward manager reviewed the incidents, they provided feedback and emailed the person who had raised the incident. A hard copy was also kept of the incident and the response. Incidents were discussed at safety huddles and then once a month at the team meeting. All members of the ward staff were present at the safety huddles.

There was a notice board on ward 41 which provided information to staff and patients about the duty of candour.

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.

From December 2017 to November 2018, the trust reported no incidents classified as never events for medical 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 11 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>9</td>
<td>81.8%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Strategic Executive Information System (STEIS))*

There was a serious incident report that went to the quality and governance committee who escalated appropriate issues to the board.

**Safety thermometer**
The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The trust had undertaken a collaborative programme on pressure ulcers with NHS Improvement. The trust had set themselves some targets, one of which was for no grade four hospital acquired pressure ulcers. During the programme, the trust were awarded the most innovative idea and were the most improved trust in the six month programme. At the start of 2016 to 2017 the hospital avoidable harm pressure ulcers was at 58% and to date in 2018-2019 this had fallen to 19%. There had been no grade four pressure ulcer in 2018 to 2019.

The trust had invested in new mattresses and there was a change in focus for the tissue viability nurses with more teaching for staff and “toolboxs” to help them prevent pressure ulcers and prevent deterioration of any existing pressure ulcers.

All the wards had charts on the walls which indicated when the last fall had occurred and when the last pressure ulcer had occurred. There was also information about infections including MRSA and the incidence of urinary tract infections. Numbers of complaints and compliments was also shown.

On ward 41 we saw in February 2019 that there were no falls with harm, no incidences of MRSA or Clostridium difficile, no venous thromboembolisms, no urinary tract infections and one new pressure ulcer.

On ward 40 information was displayed at the entrance to the ward. December 2018 to February 2019 data showed there had been one fall, one MRSA/Clostridium difficile infection and one new pressure ulcer on the ward.

If patients did fall then a post fall action record was put in place to try to prevent further falls.

On ward 44 in the 12 months following the completion of the enhanced care collaborative the ward had seen no avoidable venous thromboembolism incidents, no category four pressure ulcers, and an improvement in infection control measures.

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 66 new pressure ulcers, 23 falls with harm and nine new urinary tract infections in patients with a catheter from November 2017 to November 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Tameside and Glossop Integrated Care NHS Foundation Trust

1
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Insert commentary on any trends.

(Source: NHS Digital - 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. Managers ensured that staff followed guidance.

Policies and procedures followed recognisable and approved guidelines, such as the National Institute for Health and Care Excellence (NICE).

The clinical audit and effectiveness team were responsible for the dissemination, implementation and monitoring of guidance from the National Institute of Health and Care Excellence (NICE) which had been assessed as relevant to the trust. Guidance was circulated to clinical teams for review and completion of an assessment tool which had sections for compliance, implementation and planning. There was a trust database that measured the receipt, review, implementation and areas of non-compliance.

Patient pathways were based on evidence based practice from NICE and the Royal Colleges. The patient pathways on the trust intranet so that staff could easily find them if necessary.

We observed in patient records that the staff were using pathways for care of their patients, there was a pathway for shortness of breath and one for cardiac chest pain.

The physiotherapy service led the non-invasive ventilation service. The service was working towards the British Thoracic Society and Intensive Care Society guidance (2016).

The endoscopy unit were developing and improving their standard operating procedures for their Joint Advisory Group accreditation on gastro-intestinal endoscopy.

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.

In records that we reviewed we saw that the malnutrition universal screening tool (MUST) charts had been completed appropriately.

The MUST overall audit scores for the trust had gone from 54% in May 2018 and steadily increased to 81% in November 2018.

There was currently an audit ongoing on percutaneous endoscopic gastrostomy (PEG) and collecting data on number of referrals, time of wait until procedure, number of incidences of bloods or antibiotics not given and 30-day mortality. The trust were going to introduce a PEG passport for all patients who had a PEG inserted in Tameside.

The enhanced care collaborative on ward 44 had introduced a dementia board round to identify patients at risk of malnutrition and dehydration who might not trigger a MUST assessment. This allowed for early intervention for these patients.

On ward 45, the stroke rehabilitation unit, there was a nutrition board which highlighted changes made following feedback from the dietitian and the specialist nutrition nurse. These included examples of correctly completed food record charts and fluid balance charts. There was patient safety information about enteral feeding and nutrition and hydration delivered by naso-gastric tubes and PEG and how these feeds needed to be checked by two qualified staff. There was training for naso-gastric tube insertion.
The correct completion of MUST charts was a topic on the board on ward 45. Staff had also received training on how to thicken fluids for the stroke patients. Dietitians and speech and language therapists worked together in the assessment of patient’s swallowing and the impact of this on their nutrition and hydration.

In the patient record of a patient on ward 45 we saw that there was an entry which stated that “due to cognitive impairment there was a high risk that they will not take adequate diet and fluids” and there was a plan in place to ensure that the patient did receive adequate nutrition and hydration.

On ward 41 the audit board showed that MUST scores were at 100%. We observed that the nursing staff checked how much patients had eaten and they asked patients to drink more and observed them while they did it.

Patients on the endoscopy unit were offered tea and toast following their procedure.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The admission documentation on the acute medical unit included information about pain and any analgesia that the patient was taking.

We observed that on the medicines round on ward 45 the nurse asked patients about their pain and if they required analgesia. They also asked what form they wanted this analgesia in e.g. tablet, liquid. In a patient record we saw that the Abbey pain had been used; this is used for patients with cognitive impairment to identify if they are in pain.

On ward 41 there were picture cards so that patients with a learning disability could point to where their pain was. There were link nurses for pain management.

Patients who were having an endoscopy were offered sedation before their procedure or Entonox. In the patient’s care plan there was a checklist for examination prior to the administration of Entonox for staff to complete. Pain levels were recorded during the procedure using the Leeds comfort scale.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. There was a medical audit group that met every two months to review and learn from audit outcomes.

On the stroke rehabilitation unit there was a weekly multi-disciplinary team meeting where all the patients on the ward were discussed including whether the patients had improved or deteriorated since the previous week. Patient goals could then be adjusted as appropriate. The Barthel score was used to measure performance in activities in daily living.

There was an older persons RAID team which was for the detection, assessment, treatment and care of older people with mental health problems who were in-patients at the hospital. Staffing for the team was from a nearby mental health trust. There were records of these visits including interventions from consultant psychiatrists in patient records.
We saw in a patient record that there was good documentation about a patient’s challenging behaviour and disorientation in the care plan and how this was to be managed on the ward. The plan described how the patient’s safety was to be maintained and the outcomes of best interest’s meetings.

Patient outcomes were well documented in records we saw on ward 41, there were comprehensive plans for patients with goals and documentation about how goals had been achieved.

One of the aims of accreditation from the Joint Advisory Group (JAG) for endoscopy was to improve patient outcomes and improve patient experience, the endoscopy department was working towards their accreditation.

**Tameside General Hospital**

From July 2017 to June 2018, patients at Tameside General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Patients in gastroenterology and clinical haematology had a lower than expected risk of readmission for elective admissions.
- Patients in pain management had a higher than expected risk of readmission for elective admissions.

**Elective Admissions - Tameside General Hospital**

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 represents the opposite. Top three specialties for specific site based on count of activity.

From July 2017 to June 2018, patients at Tameside General Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine and geriatric medicine had a similar too expected risk of readmission for non-elective admissions.
- Patients in cardiology had a lower than expected risk of readmission for non-elective admissions.
Non-Elective Admissions - Tameside General Hospital

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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/07/2017 - 30/06/2018))

Sentinel Stroke National Audit Programme (SSNAP)

The trust participated in the SSNAP audit as a non-routinely admitting acute team. Previous actions from the stroke audits included:

- Junior doctor induction training on stroke and transient ischaemic attack pathways
- Stoke team attended daily board rounds on the acute medical unit to identify overnight stroke admissions
- Liaison with community teams including daily handover with the community rehabilitation team and stroke association long term support
- Occupational therapists and speech and language therapists looking at increasing group work to maximise input from patients and improve social interaction.

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

Tameside General Hospital

The table below summarises Tameside General Hospital's performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>89.9%</td>
<td>Does not meet the audit aspirational standard</td>
<td>x</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>37.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery
(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen) 22.0% Within expected range ✓

Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment
(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen) 50.5% Within expected range ×

Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy
(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen) 59.5% Within expected range ×

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Tameside General Hospital

The table below summarises Tameside General Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>No</td>
<td>n/a</td>
<td>×</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>96.7%</td>
<td>Green</td>
<td>×</td>
</tr>
</tbody>
</table>
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable)  
(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)  
| 0.0% | Red | ✔ |

Crude proportion of patients assessed for the presence or absence of delirium (if applicable)  
(Having an assessment for delirium is indicative of good practice in falls prevention)  
| 3.3% | Red | ✔ |

Crude proportion of patients with a call bell in reach (if applicable)  
(Having a call bell in reach is an important environmental factor that may impact on the risk of falls)  
| 70.0% | Amber | ✔ |

(Source: National Audit of Inpatient Falls)

The trust was working on a falls improvement collaborative. The aim of the programme was to reduce the numbers of falls in hospital, to reduce the numbers of patients admitted with a fall, to reduce the harm from falls and to reduce the number of patients admitted with a hip fracture.

A falls collaborative group had been set up and a lead nurse for quality improvement with a focus on falls. The falls nurse was reviewing all incidents and provided “toolbox talks” to staff on the wards where they worked. There were also root cause analysis panels looking at falls. The falls work also linked into the ongoing work on frailty. There were lessons learned from the collaborative actions for the future.

Chronic Obstructive Pulmonary Disease Audit

The table below summarises Tameside General Hospital’s performance in the 2018 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>
| Percentage of patients seen by a member of the respiratory team within 24hrs of admission?  
(Specialist input improves processes and outcomes for COPD patients) | 37.0%                | Worse than the national aggregate | ✔                        |
| Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)  
(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death) | 94.5%                | Worse than the national aggregate | ✔                        |
Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission) | 27.9% | Better than the national aggregate | ✗
--- | --- | --- | ---
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD) | 13.6% | Worse than the national aggregate | ✗
--- | --- | --- | ---
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care) | 25.6% | Worse than the national aggregate | ✗
--- | --- | --- | ---
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt) | 16.5% | Worse than the national aggregate | ✗

(Source: Chronic Obstructive Pulmonary Disease Audit)

The trust was using patient activation measures to assess whether patients with high levels of activation could receive structured education and the other patients supported to improve their level of activation. They had also reviewed their standard operating procedures to ensure they covered all the elements of the audit.

National Audit of Dementia

The table below summarises Tameside General Hospital’s performance in the 2017 National Audit of Dementia.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>88.2%</td>
<td>Top 25% of hospitals</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service able to respond to the needs of people with dementia as they arise?”</td>
<td>93.1%</td>
<td>Top 25% of hospitals</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)

<table>
<thead>
<tr>
<th>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</th>
<th>24.0%</th>
<th>Bottom 25% of hospitals</th>
<th>No current standard</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</th>
<th>83.3%</th>
<th>Middle 50% of hospitals</th>
<th>No current standard</th>
</tr>
</thead>
</table>

(Source: National Audit of Dementia)

The medicine directorate had worked with other areas of the trust to audit fluid balance and acquired kidney injury (AKI). This was the third audit of AKI and each new audit showed improvements which included:

- a revised care bundle for AKI
- training provided for all staff on the wards
- stage two to three AKI identified and attended by the clinical effectiveness nurse
- awareness raised through trust presentations
- AKI included in trust induction for medical and nursing staff
- an improving AKI intranet page developed.
- new fluid balance charts developed and launched

There had been a sepsis Commissioning for Quality and Innovation (CQUIN) in 2017/18

The outcomes of the CQUIN were:

- a clinical effectiveness nurse lead for sepsis
- raising of awareness through divisional meetings and trust events
- sepsis training at induction
- sepsis recognition and treatment guidance for clinical staff

A benign polyp multi-disciplinary team meeting had been established in the endoscopy unit, this was to reduce variation and improve patient outcomes.
The stroke service had completed an audit to improve venous thromboembolism prophylaxis in stroke patients which would improve compliance with national guidelines and reduce mortality. The audit showed that there had been an increase in intermittent pneumatic compression delivered to appropriate patients during August 2018 to November 2018 in line with national guidelines.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance to provide support and monitor the effectiveness of the service. All the staff we spoke with had an annual appraisal with their managers and qualified staff had one to one meetings.

The clinical practitioner on the AMU arranged training for qualified staff and unqualified staff. The qualified staff had received training for infection control, blood transfusion, aseptic non-touch technique and diabetic ketoacidosis. The non-qualified staff had received training for tissue viability, infection control, nutrition and basic life support.

The clinical practitioners did competency training in the AMU bays so that all staff could attend. There had been a number of study days on the AMU including days for diabetes, acute illness management, critical care skills outreach training, sepsis 6 and prevention of pressure ulcers. Training was evaluated and we saw that there was positive feedback from staff about training. The clinical practitioners had their own pages on the trust intranet to support staff in their learning and development.

There was a trainee assistant practitioner on the cardiology ward who spent time training on the ward and time at the local university. They worked in cardiac procedures supporting day cases like loop recorders and pacemakers and they worked on the acute cardiology unit supporting patients. They will qualify as a band four assistant practitioner later this year.

The specialist nurse for cardiology had run a training day including topics such as cardiac rehabilitation, heart failure and basic electrocardiogram(ECG). Staff could also take up the acute airway recognition module that was available from the Critical Care Skills Institute in Manchester. This was competency based training.

There was multi-disciplinary in-house training for staff on the stroke rehabilitation ward. One of the doctors also provided weekly training in 15-minute slots for staff and one of the doctors was shadowing the allied health professionals on the ward to learn more about the different therapies.

On the stroke rehabilitation ward staff had received “toolbox talks”, one of these had been from the dietitian and the specialist nutrition nurse about nutrition and hydration in patients following a stroke, they had also developed a resource pack to support staff. There was a student board on the ward with information about workshops available to students and other areas of interest including sepsis, the deteriorating patient, alcohol liaison services and dementia. Student comments were very positive and they said that they had learned a lot from their placements on the ward.

The non-invasive ventilation service was led by the physiotherapists. They were available 24 hours a day. The physiotherapists provided training for staff on the use of non-invasive ventilation
(I have requested the SoP and numbers of trained staff but they said all were trained except new starters)

The physiotherapists had monthly one to one sessions with their line manager and an annual appraisal and objectives.

The medical directorate provided some training for GP practice nurses

There was a board in the endoscopy unit with the skills and competencies of everybody in the department so that staff could see at a glance who they needed to meet the treatment needs of the patient list. All skills and competencies were documented for the Joint Advisory Group accreditation.

The endoscopy unit had a training day twice a year. This was for all staff and included training and development with the representatives of the equipment companies invited to give training updates on equipment. The unit had developed a competency framework for the decontamination staff.

From April to November 2018, 85.9% of required staff in medical care received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>14</td>
</tr>
<tr>
<td>Qualified allied health professional</td>
<td>23</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>9</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>262</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>200</td>
</tr>
<tr>
<td>Other non-medical staff</td>
<td>53</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>608</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, other healthcare professionals supported each other to provide good care.

The medical directorate worked with other organisations to share staff and maximise expertise and resources where appropriate. An example of this was the dementia strategic lead post with a nearby mental health trust and the treatment of upper gastrointestinal bleeds out of hours.

The medical directorate had worked closely with the local authority over the issue of stranded patients; there were no patients who had been in the hospital for more than 100 days.

There was good multi-disciplinary working on the AMU which was demonstrated at the daily board rounds. We observed that staff worked well together to improve patient outcomes.

On the acute cardiology ward, we observed close working between the nursing staff and the consultants and staff told us that working relationships were good. We observed that there was close working between the acute cardiology ward and the acute medical unit.

On ward 45 there was strong evidence of multi-disciplinary working in the weekly multi-disciplinary team meetings but also in the ward. The team included physiotherapists, occupational therapists, social workers, nurses, speech and language therapists, dieticians, specialist nurses and representatives from the stroke association.

We observed partnership working on ward 41 between nursing staff, doctors, occupational therapists and specialist nurses.

There was a multi-disciplinary meeting every week in the endoscopy unit to discuss the patients on the two-week treatment list, this included booking scheduling staff.

The endoscopy productivity project had involved ward managers and staff, medical staff including consultants and junior doctors, endoscopy nurses, the admissions access manager, the booking team leader information technology staff and the service improvement manager.

### Seven-day services

The trust was working towards seven-day services and there was a strategy for the implementation (2018 to 2022). They were developing pathways with clinical teams to support this work. Some services would need additional investment and the trust was working with the local clinical commissioning group to look at different models of working. Some support services had been enhanced to support seven-day working including housekeeping, pharmacy services and allied health professional services. Seven-day working was on the trust risk register.

There were two main issues for seven-day working, one was the daily patient review. The trust had held workshops to review this and there was agreement that not all patients needed a consultant review and if an appropriate pathway was in place, this could then be delegated to other staff.

The second issue was the 14-hour assessment of patients. A newly admitted patient must be reviewed by a patient after arrival on the acute medical unit. A business case had been submitted and the consultant rota had been reviewed and additional consultants were required to meet the 14-hour target.

Part of the endoscopy productivity project was to introduce seven-day working for all nursing and technical staff working in the unit. The unit was working with other providers in Greater Manchester for out of hours provision.
Health promotion

There were a range of leaflets on the cardiology ward relating to cardiac conditions, some of the leaflets were from the British Heart Foundation. There were also leaflets for “this is me” and leaflets to highlight the symptoms of tuberculosis.

On ward 45 there was a leaflet that was “a practical guide to healthy ageing” which contained information about falls prevention and positive mental health.

On ward 42 there was information about support for people with drug and alcohol problems. Smoking status and referrals to smoking cessation support were made. The smoking cessation support had been continued by the trust based on the needs of the population.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

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.

The Mental Capacity Act (MCA) is in place to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

The qualified staff on the AMU had received training in Deprivation of Liberty Safeguards (DoLs) as part of their study day.

The social worker undertook capacity assessments on patients on the stroke rehabilitation unit, they told us that they did three assessments before they documented the patient’s capacity. Best interests meetings were held for patients if there was no power of attorney. We saw that these were documented in the patient’s records. The social worker was also involved in the application for continuing health care funding.

On ward 42 the ward manager said that they would complete best interests assessments for the patients and would be heavily involved in the DoLS applications but it was usually the medical staff who did the capacity assessments.

On ward 41 (dementia and older people) the ward manager told us that they did the capacity assessments for the patients. They would wait 24-48 hours before they completed the assessment so that the patient could settle in. The manager also did the best interests meetings for the patients often contacting the patient’s relatives by phone as many were elderly. They told us that they used independent medical advocates as appropriate. The ward manager worked with the local council when completing the DoLS assessment and documentation and said that they were supported by the safeguarding team.

On ward 41 there was a board with information about DoLS including things that staff needed to consider when making a DoLS application and when it was appropriate to deprive someone of their liberties. There was a brief guide to the mental capacity act in practice which included best interest decisions and the least restrictive options.
There were mental capacity smart cards which were a reference tool for healthcare professionals to support decision making regarding mental capacity for adults. Information included capacity assessments, type of decisions, emergency or urgent decisions, non-urgent decisions, best interests, the use of independent mental capacity advocate and Deprivation of Liberty Safeguards. There was a single page flowchart and contact details for legal services including out of hours.

There was guidance for staff completing best interests documentation to consider patients with delirium or a urinary tract infection that could cause confusion and waiting to see if any symptoms cleared before making an assessment.

Any decision for “do not resuscitate orders” was included in the discharge information for patients so that decisions made in hospital would be communicated to patient’s GP’s for future reference.

The trust set a target of 80% for completion of mental capacity act training.

From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 81.3% of all staff in medical care compared to the trust target of 80%.

A breakdown of compliance for mental capacity act level 2 training from December 2017 to December 2018 for qualified nursing and medical staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>191</td>
<td>222</td>
<td>86.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>49</td>
<td>73</td>
<td>67.1%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Qualified nursing staff in medical care met the trust target of 80% with a completion rate of 86.0%.

Medical staff in medical care did not meet the trust target of 80% with a completion rate of 67.1%.

(Source: Routine Provider Information Request (RPIR) – Training tab)
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 saw thank you cards around the hospital from patients and their relatives thanking staff for their care. There were three on ward 45, one said thank-you for your help and understanding and another said thank-you for your care, attention and support. On ward 41 there were three cards, one thanked staff for making the family welcome, one thanked staff for their care and compassion and the other described staff as angels.

We observed an interaction between a nurse and a patient on ward 45. The nurse spoke in a friendly way to the patient, they asked permission before moving their arm and explained that they would be giving them their medicines. We also observed an interaction between a porter and a patient, the porter knew the patient by name and was friendly towards the patient.

We spoke with two patients on ward 45, one of them described their care as “first class.” The other said that the care had been good and that there had been no problems with their hospital stay.

On ward 40 we observed all staff introducing themselves to patients. We observed staff actively asking relatives if they could offer help. A housekeeper was observed offering drinks and speaking with patients respectfully.

On all wards we saw that staff and volunteers helped patients with their eating and drinking. There were dining companions who were volunteers who were trained to assist patients at meal times. They wore a coloured apron so that staff and patients knew who they were.

We observed that the patients preferred name was documented in their records and that that staff used this when talking to or about patients.

Patients who were discharged at Christmas received a food hamper and there had been a Christmas grotto for patients in the hospital.

The Friends and Family Test response rate for medical care at the trust was 36% which was better than the England average of 24% from January to December 2018.

Tameside General Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp.</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Cardiology Unit</td>
<td>502</td>
<td>59%</td>
<td>95% 100% 95% 95% 95% 95% 100% 100% 100% 96% 98% 98% 98%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 42</td>
<td>497</td>
<td>66%</td>
<td>96% 100% 100% 100% 100% 100% 94% 90% 91% 97% 100% 100%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 31</td>
<td>399</td>
<td>41%</td>
<td>92% 100% 97% 96% 100% 100% 96% 89% 94% 97% 100% 95%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 40</td>
<td>361</td>
<td>36%</td>
<td>95% 100% 93% 96% 100% 91% 88% 94% 96% 98% 100% 94%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 46</td>
<td>358</td>
<td>62%</td>
<td>86% 100% 100% 100% 91% 100% 100% 100% 96% 95% 94%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 41</td>
<td>330</td>
<td>45%</td>
<td>97% 89% 100% 100% 87% 84% 65% 91% 100% 90% 84%</td>
<td>87%</td>
</tr>
<tr>
<td>Ward 44</td>
<td>317</td>
<td>63%</td>
<td>91% 81% 100% 100% 94% 80% 91% 100% 96% 95% 100%</td>
<td>92%</td>
</tr>
<tr>
<td>Ward 45</td>
<td>213</td>
<td>94%</td>
<td>89% 93% 100% 96% 100% 88% 81% 87% 100% 79%</td>
<td>79%</td>
</tr>
<tr>
<td>Heart Care Unit</td>
<td>195</td>
<td>32%</td>
<td>96% 98% 100% 95% 100% 100% 91% 88%</td>
<td>92%</td>
</tr>
</tbody>
</table>

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1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

2. Sorted by total response.

3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress when appropriate.

Volunteers provided social interaction for certain patients to help to reduce the risk of falls, distressed behaviour and to reduce anxiety.

We observed that staff comforted patients when they were distressed and that there were positive relationships between staff and patients especially for those who had been in hospital for a long time. Staff went out of their way to engage with patients especially if the patients were down or needing cheering up.

There were mood scoring tools and depression questionnaires that were completed and appropriate referrals for psychiatric assessment. Anti-depressants were prescribed if appropriate.

We noted in a patient record that the care plan stated that a patient would require emotional support during their hospital stay.

On ward 45 there was information for patients about requesting a visit from a chaplain for spiritual or emotional support.

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.

The trust had been involved in an enhanced care collaborative on ward 44 to improve the quality of enhanced care and the patient/carer/family experience and to improve the promotion of carer/family involvement in enhanced care. The ward was a general medical ward with a focus on patients living with dementia. It was also the emergency orthopaedic unit which had a high number of patients admitted following traumatic incidents and falls and many of these patients were living with dementia and had enhanced care needs. The aim of the programme was to enhance the quality, safety and patient experience of one to one care, to deliver a better experience for the patients and to measure, monitor and reduce the cost of one to one care. This had led to safety huddles every 24 hours with an emphasis on reassessment and care planning with the family involvement, family/carer surveys and leaflets and open visiting using visitors passes. There was learning from the collaborative with actions moving forward. There was positive feedback from patients on the ward with an improvement in patient safety and an over 50% reduction in safety incidents.

Multi-disciplinary team meetings on ward 45 involved discussion about patient’s social circumstances and their families and the impact, including the emotional impact, that the patient’s
condition had on the family. There were meetings between the families and health professionals and social workers to discuss and agree the patient’s discharge destination.

A patient on ward 45 told us that there were kept updated about their care and treatment and that their relatives had been involved in decisions about their care. Another patient relative told us that staff kept them informed and that they were friendly.

As a result of “you said, we did” ward 45 had developed a night time etiquette standard as patients had complained that it was noisy and they were unable to sleep.

We observed the health care assistant on the stroke rehabilitation unit blow-drying patient’s hair. The patients told us that having their hair done made them feel better.

Staff on ward 41 went above and beyond for patients on the ward. They had put on a number of events, including a sponsored parachute jump, to raise money for projects which included the development of corner cottage, a flat decorated and furnished in the style of a 1950’s sitting room, a hair and nail salon and a flat for couples on the ward to be together at the end of life.

On ward 41 we saw that staff talked with patients and their relatives, staff were allocated to certain bays on the ward and so had an awareness of patients and their care on 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.

The acute medical unit had six bays and five isolation rooms that could be used for patients with infections.

The acute cardiology ward had 15 beds with telemetry available at each bed. There was open visiting on the ward though meal times were protected. There were three side rooms with bedside monitors.

Ward 45 was the stroke rehabilitation ward and had 24 beds. Patients who had suffered from an acute stroke received treatment at local trusts that had a hyper acute stroke unit. They were repatriated to their nearest hospital for stroke rehabilitation within 72 hours if they were medically fit.

There were link nurses on ward 41 for a range of conditions including dementia, pain, infection control, heart failure, sepsis, end of life care, learning disability, falls, alcohol and diabetes. There was open visiting on the ward.

The endoscopy unit had an accreditation visit from the Joint Advisory Group (JAG) on gastrointestinal endoscopy from the Royal College of Physicians in October 2018. The accreditation had been deferred and the service had an action plan to meet the outstanding requirements for their accreditation. A further visit was planned for June 2019 to review progress on the action plan.

The endoscopy unit had a main waiting area and patients were admitted into private rooms to prepare for treatment, each of the private rooms had its own toilet facilities with a pull cord.

There were three endoscopy theatres, one of which had X-ray facilities so that patients did not have to go to the diagnostic imaging department if they needed X-ray guided procedures. All rooms and toilets had access for those with mobility issues. There was a recovery area with 15 beds where staff were taken following their procedure.

The criteria for the discharge lounge, when in use, were set out for staff on ward 45 to facilitate prompt discharge.

Meeting people’s individual needs

The service took account of patients’ individual needs especially people in vulnerable circumstances. They provided informed choice and continuity of care and reflected peoples individual needs and preferences. Patients and their carers were central to the delivery of services.

The trust was trying to improve pathways of care for patients with dementia so that when they were admitted to hospital they went straight to an appropriate ward instead of going to urgent and emergency care and possibly the acute medical unit.

There was a hospital passport for patients with a learning disability which contained details of the patient’s main carer, their learning disability nurse, social worker and any district nurses involved in their care. The passport contained “things you must know about me” including what I like to be called, “things that are really important to me” and “things I like/don’t like”. There was also a prompt
for staff that the patient may have capacity to consent to some care and treatment and not others. Any learning disability was documented on admission to a ward and we saw that this had been documented in appropriate patient records.

We observed on ward 45 that there was patient information available for the relatives and carers of those coming into hospital with dementia or enhanced care needs. There was information available from a number of charities who support older people and those with cognitive impairment. There was information available from the local authority about support for those who were carers.

There was a stroke association board on the ward with information about activities. There was a stroke café that was held once a month on the ward for patients and their relatives and carers. There was also a “shed” where patients, following discharge, could attend workshops on woodworking and cycle repair. There was also a cinema club.

The hospital commissioned a service from the stroke association to support patients for a year following a stroke to provide practical and emotional support to patients and their relatives.

Information sheets on ward 45 were available in different languages which reflected the diversity of the local area. Patients could also request leaflets in different languages.

There was an occupational therapy kitchen where patients could practice activities of daily living and we saw that there was a breakfast club where patients made their own breakfasts as part of their rehabilitation. There were group exercises that were supervised by an occupational therapist and a technical instructor. The radio was on and we observed that patients participated in the activities and socialised with each other.

Some of the patients on ward 45 had communication books to help them and meal choices were available in picture format if necessary.

There was a learning disability folder on ward 41 which contained useful information for staff. There were picture cards so that patients could point to where their pain was and other cards for where they might be having an injection, if a scan was required or a plaster cast. There was a learning disability protocol which was the complete admission procedure for the admission of a patient with a learning disability. The protocol involved talking to the learning disability liaison nurse who was also to be involved in the discharge of the patient. There was information about an incident that had occurred with a patient with a learning disability and the learning from the incident.

On ward 41 (dementia/adult medicine) there were four boards near the ward entrance one, one contained information about learning disabilities including advice re written communications, speaking in the first person, environment etc. There was also admission criteria for the ward which created an alert on the electronic system so that staff were aware that the patient had a learning disability, a referral to the learning disability team, information about family and carers and any reasonable adjustments.

The second board was about dementia and had information and advice for families about caring for patients with dementia, facts about dementia and information about support e.g. dementia cafes and complimentary therapies.

On ward 41 staff had raised funds for a day room which was decorated and furnished in 1950’s style, this was “corner cottage”. The room was used for meetings with families and carers and staff told us that a patient who had been very unsettled on admission to the ward had used the room and had become much calmer, they had slept in the room during their hospital stay. Staff had
raised further funds and one of the bathrooms was going to be a salon so that patients could get their hair and nails done.

There was appropriate signage on ward 41 for patients with cognitive impairment. There was an activities co-ordinator and we saw that there were patient activities including karaoke and singalong sessions. Staff were raising money to support furnishing a flat on the ward where couples could stay together during their time on the ward, particularly patients at end of life. The trust had provided some funding towards this project.

In the endoscopy unit there were two nurse endoscopists, one for upper gastro intestinal endoscopy and one for lower gastro-intestinal endoscopy. Another member of staff had been accepted onto the training course.

Staff on the endoscopy unit described how they used translators in the department and how they used them for consenting to procedures with the translator followed the patient into the theatre.

When treating patients with a learning disability staff told us that they worked with patients and carers to support patients. Individual plans were developed for patients and on occasions, patients had gone straight to theatre to avoid spending too much time in the department before the procedure. Staff told us how they had visited a patient’s house to support them in the process. Carers could stay with patients during the procedure if appropriate and patients could be sedated. Best interests meetings were held for patients when necessary. Staff were always supported by the learning disability liaison nurse.

The department had started using Entonox for pain relief, if patients opted for Entonox instead of sedation it meant that they could drive themselves home.

Access and flow

There had been significant work undertaken to improve access and flow through the services provided in the medical directorate which had shown a reduction in length of stay, a reduction in patient cancellations and a reduction in long stay beds. There was also a reduction in hospital readmissions for some patients.

The trust had looked at improving system flow to support stranded and super stranded patients. These are patients who remain in hospital after being medically optimised for discharge for seven days and 21 days respectively. A number of processes had been introduced that supported this and we saw these in operation during our inspection. These included the red/green dashboard that highlighted delays in care progression, daily board rounds, new models of care and other interventions to reduce length of stay in the hospital. As a result of these measures the trust was the third best performing trust nationally for the percentage reduction in long stay beds as of December 2018. There were no patients in the hospital that had been there for longer than 100 days. This work had also shown a reduction in the of medical outliers due to bed occupancy being reduced and appropriate beds being made available

There were three daily board meetings on the acute medical ward (AMU). The first was at 8.00am and was attended by the team leader from AMU, the consultant, the bed manager, the admission avoidance representative, the therapy lead and the clinical practitioner. Any empty beds were identified and any potential discharges were also identified. Each patient was reviewed on the AMU tracker. We saw during our inspection that beds were being freed up on the AMU allowing a flow of patients from the urgent and emergency care department.
At midday there was a full multi-disciplinary board round with the team leader, the bed manager, consultants from each team, the admission avoidance representative, occupational therapy and physiotherapy leads, specialist nurses from cardiology and diabetes, community staff and the pharmacist from AMU. We saw that the meetings supported transfer to more appropriate wards in the hospital and identified patients who were suitable for discharge. Community staff identified patient needs to enable discharge and diagnostic delays were followed up.

There was a board round at 15.00pm with the consultants, junior doctors, the AMU team leader and the bed manager. This meeting confirmed that referrals to other members of the multi-disciplinary team had been made and that discharge summaries and transport arrangements had been made. The clinical status of patients and their care plans were also reviewed.

All patients were discussed at the board rounds with their estimated discharge dates. Patients names changed colour on the board so staff could easily identify if a patient required a consultant review or the care of a particular specialty. Patients who were able to, sat out in the day room or discharge area whilst waiting for medication or transport home to free up beds.

We saw on ward 41 patients were categorised into red and green on the patient board and the red patients were discussed at the morning board round. Red indicated outstanding investigations or absence of a date of discharge. This was part of the improving system flow working.

Patients on the stroke rehabilitation ward were generally repatriated from other hospitals. Patients who had suffered an acute stroke were treated at hyper acute stroke units at nearby trusts. If medically stable, patients had to be repatriated to Tameside within 72 hours for ongoing rehabilitation. Staff used a patient acuity tool to determine which ward patients would be repatriated to if there were not enough beds on ward 45.

The respiratory service had undertaken a respiratory improvement programme in 2018. This was to help to identify patients with chronic obstructive pulmonary disease (COPD) sooner, to support and optimise the health of those with COPD to help them to be healthier for longer and to educate healthcare professionals across primary and secondary care to deliver effective care across the whole pathway. Average length of stay had remained consistent with some reductions but 30 day readmissions had shown a consistent downward trend. In September 2018 readmissions were down to 12% compared to 18.6% in September 2017 which was a drop of 6.6% and in October 2018 the readmission rate was 11.6% compared to 17.6% in October 2017, a drop of 6%. There had been an increase in readmissions in August 2018 but this was possibly due to the moorland fires in the local area.

The endoscopy unit had undertaken a productivity project which was initiated in May 2017 and lasted for 10 months. The objectives of the project were to deliver better patient experience and to improve productivity and efficiencies, this was as a result of high on the day cancellations and an increase in waiting times. There were a number of workstreams including one to understand the demand for services and the capacity to deliver the services while delivering a quality service. Another was to reduce cancellations and patients who did not attend by establishing a pre-assessment service to support patients and to prepare them for their procedure. Booking and administration systems were also reviewed.

A number of changes were implemented including a new standard operating procedures and booking systems. An online referral form and tracking system and updated bowel preparation instructions and education and training for ward staff. There were also new criteria for overnight stay patients and updated bowel preparation instructions and dietary advice leaflets for patients.
One of the nurse endoscopists now telephoned patients before their appointments to check on their understanding of the procedure and that they understood what they needed to do to prepare for their procedure. This had resulted in a drop in on the day cancellations.

Systems in the department were well organised and prompt decontamination and cleaning of scopes meant that scopes were available as necessary. There were reserved slots every day if patients needed urgent appointments. There were weekly meetings to discuss patients on the two waiting list for diagnostic testing.

**Tameside General Hospital**

From August 2017 to July 2018 the average length of stay for medical elective patients at Tameside General Hospital was 9.4 days, which was higher than England average of six days.

For medical non-elective patients, the average length of stay was 6.1 days, which was similar to the England average of 6.3 days.

**Elective Average Length of Stay - Tameside General Hospital**

![Average Length of Stay Graph]

*Note: Top three specialties for specific site based on count of activity.*

- Average lengths of stay for elective patients in gastroenterology and general medicine were higher than the England averages.
- Average length of stay for elective patients in cardiology was similar to the England average.

**Non-Elective Average Length of Stay - Tameside General Hospital**

![Average Length of Stay Graph]

*Note: Top three specialties for specific site based on count of activity.*

- Average length of stay for non-elective patients in general medicine was similar to the England average.
- Average length of stay for non-elective patients in geriatric medicine was lower than the England average.
- Average length of stay for non-elective patients in cardiology was higher than the England average.

(Source: Hospital Episode Statistics)

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

From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medical care was better than the England average.

In the most recent month, October 2018, 98.3% of patients were treated within 18 weeks compared to the England average of 88.2%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates by speciality for medical care is shown below:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100.0%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.1%</td>
<td>93.5%</td>
</tr>
<tr>
<td>General medicine</td>
<td>97.6%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.5%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>85.7%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

From November 2017 to October 2018 six specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>0.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.0%</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)
Patient moving wards per admission

From November 2017 to October 2018, 99.7% of individuals did not move wards during their admission, and 0.3% moved once. A breakdown by ward can be found below:

- Ward 31 (general medicine): 9 ward moves
- Ward 41 (general medicine): 2 ward moves
- Ward 42 (general medicine): 1 ward move
- Heart care unit: no ward moves

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From November 2017 to October 2018, there were 4,132 patients moving wards at night within medical care. The five wards with the highest number of ward moves at night were as follows:

- Acute medical unit: 3,510 ward moves
- Integrated assessment unit: 348 ward moves
- Acute cardiology unit: 172 ward moves
- Heart care unit: 22 ward moves
- Ward 40 (general medicine): 20 ward moves

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

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

There was a trust tracker for complaints and governance leads met every week to review complaints and to identify any trends in complaints. Complaints were owned in appropriate areas and these areas investigated complaints. There were sometimes issues with consultants responding to complaints but senior staff said the culture had improved. There was learning from complaints and a “closing the loop” newsletter for staff. The heat maps identified areas where there had been a number of complaints and this was followed up by the governance team.

There was a learning from experience board on ward 45 which had a negative comment about one member of staff on the ward, the follow up was that this was discussed in the safety huddle and nurses were advised to refer to the medical staff if they were unsure about anything.

On the same ward we saw that there had been eight compliments and no complaints in February 2019.

On ward 41 we saw on the “open and transparent board” that there had been 29 compliments and two complaints in February.

There was a specific process for complaints for patients with learning disabilities.

From December 2017 to November 2018 the trust received 120 complaints in relation to medical care (27.7% of total complaints received by the trust). The main subject of complaints was communications (32).

A breakdown of complaints by subject is shown below:
<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>32</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>25</td>
</tr>
<tr>
<td>Patient care</td>
<td>19</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>19</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
</tr>
<tr>
<td>Admin/policies/procedures (including patient record)</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

For the 97 complaints that had been closed at the time of data submission, the trust took an average of 46.0 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 45 working days.

The 23 complaints that had not yet been closed had been open for an average of 34.2 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From November 2017 to October 2018 there were 2,885 compliments received for medical care (21.3% of all received trust wide).

Compliments were received in all 12 months of the period. January 2018 was the month where the most compliments were received (405).

The trust reported it has identified that areas of the trust which experience a greater volume of patient attendances, such as the Emergency Department and Day Surgery Endoscopy Unit also receive the highest volume of positive comments. This is consistent with the high numbers of compliments reported by these departments directly.

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run a service providing high quality, sustainable care. Leaders were experienced and had the capability to make sure that a quality service was delivered and risks to performance were addressed.

There was strong leadership from the senior staff including matrons at the hospital, staff said leadership was much better in the past two to three years. On the wards, ward managers provided leadership to their staff and we saw excellent examples of leadership across the medical wards. The ward managers worked together and supported each other with daily support and input from the hospital matrons.

The trust had a talent management strategy which was being rolled out as part of staff appraisals; managers could identify leaders within the organisation and develop them for succession planning.

Vision and strategy

The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action. The trust worked in partnership with the local clinical commissioning groups and the local authority to develop the strategy.

There was a trust five-year strategic plan to try to improve health outcomes for the local population. The plan had four main aims which included tackling the causes of ill health, the provision of quality integrated services, development and retention of the workforce and partnership working.

There was a clinical services strategy that supported the trust five-year strategy, sections included the vision and aims, seven-day services, divisional structures and workplans, the NHS five year forward view and the devolution of health services across Manchester.

The open and transparent board on ward 41 listed the corporative objectives for 2018/9 including patients receive harm free care by increasing the safety and quality of services.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that they felt proud to work for the service and felt respected and valued.

There was a positive culture at the trust and staff worked together to try to get the best outcomes for patients. Staff told us that the leadership at the trust had changed positively over the last two to three years and that the senior team were very visible. Morale was good amongst the staff, they told us that they worked hard but that they enjoyed working there. Many staff had worked there for a long time and said that wouldn’t work anywhere else.

There was a strong link to the local community as many staff lived close to the hospital, they wanted the best for local people.

One of the ward managers who had recently been appointed told us that they had opportunities to look round other wards to identify good practice, they also told us that they were aware of what was going on in the wider organisation.

A ward manager said that they were proud of their team and that they had good communication with their team. They got positive feedback from patients and that this boosted staff morale.
A member of staff told us that they had been poorly and the trust had supported them to come back to work and arranged flexible working to meet their needs.

The culture on the endoscopy unit was described as “really good” by the staff we spoke with. Many staff had worked there for a long time and staff said that they all worked really well together.

**Governance**

There was 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 could flourish.

Medicine was part of the medicine and clinical support services division.

The trust had an integrated governance unit that worked with the divisions in the trust to report appropriate information to the trust board via the quality and governance committee. Departmental and team meetings fed into divisional safety and quality meetings who reported to the service, quality, operational governance group (SQOGG) which was a subgroup of the trust quality and safety committee which was a sub-committee of the board.

We saw the minutes of the SQOGG meetings for November 2018 and February 2019. In November, 17 people attended the meeting with 21 people giving apologies. In February, 21 people attended the meeting and 14 people gave apologies. The agenda was well structured and there was a patient improvement story. There was a section of the meeting for the medicine and clinical support services division. Actions arising from the meeting were noted and recorded.

The divisional safety and quality board meeting followed a structured agenda so that the division could feedback on quality and safety. There were representatives from across the division. Other areas of interest were invited such as infection prevention and audit.

We saw the minutes of the divisional safety and quality board from January and February 2019. At the January meeting, 14 people attended the meeting and three people gave apologies and at the February meeting 12 people attended the meeting and eight gave apologies. There was a patient story and an update on guidance from the National Institute of Health and Social Care Excellence. There were updates on alerts and summaries from infection control and pressure ulcer prevention. There was feedback from SQOGG and items to escalate to SQOGG so that information was passing up and down the organisation.

On ward 42 the agenda for team meetings included incidents, any risks, team member of the month, what had gone well over the month and who’s my hero awards.

On the endoscopy unit there was an online newsletter for staff with updates and information.

The consultants had done team job plans and the trust had developed job planning for allied health professionals and specialist nurses. This had been presented at a national forum.

The trust was an outlier for sepsis and had undergone an external review with an associate medical director from another trust. There had been some coding issues and there had been a review of sepsis care. There was a mortality review steering group and the trust were undertaking comprehensive mortality reviews.

There were lessons learned from the endoscopy productivity project and recommendations had been agreed with continued development of the service.
Management of risk, issues and performance

There were effective systems in place for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. There was a divisional risk register in place and service leads discussed and reviewed risks on the register. Managers were clear about the most serious risks within their service.

Departmental risks were raised on the electronic risk register which was part of the safeguarding system. Risks were escalated by the divisional leads to the trust risk management group and if necessary to the corporate risk register which was reviewed by the board.

There was a performance review dashboard for medicine and clinical support services. The dashboard included information about referral to treatment times, cancer waiting times, stroke, never events, patient experience, infection prevention, activity and efficiency and mortality. This came out every month.

There was also a “heat map” for inpatient ward areas. This provided information about staffing, compliments, complaints, moderate harm incidents, falls with harm infections and pressure ulcers. The chart was RAG rated to indicate issues of performance.

A pressure ulcer prevention group had been established which met monthly to look at any root cause analyses of pressure ulcers and any themes. Senior managers said that there was good reporting of trust acquired pressure ulcers.

Information management

Information was managed appropriately. It was collected, analysed, managed and used well to support activities, using secure electronic systems with security safeguards.

There were a number of dashboards that were used to review performance and improve quality.

Engagement

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

The trust has engaged with the community and voluntary sector and patient user groups in the development of new models of care.

Some of the wards had volunteers to help support the staff, we spoke with a volunteer on ward 45 who told us that they were well supported on the ward and that they enjoyed volunteering on the ward. They helped serving breakfasts to the patients and worked about two hours a day.

Learning, continuous improvement and innovation

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

The medicine directorate had undertaken a number of collaboratives to improve services and access and flow through services. These included a falls collaborative, the redesign of endoscopy services and the improvement in access and flow through urgent and emergency care and the acute medical unit and the rest of the hospital. We saw that these collaboratives and redesign of services was impacting positively across the whole health economy.
## Maternity

### Facts and data about this service

The Tameside and Glossop Integrated Care NHS Foundation Trust has 40 maternity beds. Inpatient services include a central delivery suite containing two midwife-led birthing rooms, maternity triage and an antenatal and postnatal ward with maternity theatres.

The trust provided the following information about their maternity services:

The trust has an integrated maternity model covering hospital and community services. There are approximately 2,400 births a year with an additional 600 women receiving care in the community antenatally and postnatally but giving birth in one of the neighbouring maternity units. Both consultant-led and midwifery-led pathways are in place, and women are sign-posted to appropriate pathways as a result of initial and on-going risk assessment. Pathways are in place for women with more complex pregnancies or needing specialist input, diabetes for example, and an enhanced model of midwifery care is established for the most vulnerable families.

Care in the community is delivered at a range of venues across Tameside and Glossop, whilst hospital care is delivered from Tameside General Hospital. The unit consists of an antenatal clinic (ANC) that was fully refurbished in 2017, a maternity ward with antenatal and postnatal beds, and a Central Delivery Suite which currently also contains two midwife-led birthing rooms, in anticipation of a new alongside midwifery-led unit opening by Summer 2019. A home birth service is also provided by the Trust.

The dedicated obstetric theatre is accessed directly from the delivery suite. Triage, antenatal assessment and ultrasound are also delivered from the unit. Postnatal care is delivered from a variety of settings including at home or at a choice of postnatal clinics in both hospital and community venues.

There is a specialist diabetes multidisciplinary team clinic, that includes a diabetologist, obstetric consultants with a specialist interest in diabetes, diabetes specialist nurses and midwives. As well as the standard antenatal sonography service, there is an established fetal surveillance midwifery service, with additional midwives undergoing training.

The maternity service also has a midwife with special interest in bereavement support, along with an expanding smoking cessation service, infant feeding support midwives, and screening specialist midwives.

*(Source: CHS Routine Provider Information Request (RPIR) - Context CHS tab / Routine Provider Information Request (RPIR) Universal – Sites tab)*
From July 2017 to June 2018 there were 2,293 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at Tameside and Glossop Integrated Care NHS Foundation Trust – Comparison with other trusts in England.**

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below. Please note, this excludes any deliveries where the delivery method is ‘other’ or ‘unrecorded’.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,271</td>
<td>98.6%</td>
</tr>
<tr>
<td>Multiple</td>
<td>32</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>86</td>
<td>3.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>1,831</td>
<td>79.5%</td>
</tr>
<tr>
<td>35-39</td>
<td>330</td>
<td>14.3%</td>
</tr>
<tr>
<td>40+</td>
<td>56</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,303</td>
<td></td>
</tr>
</tbody>
</table>

*Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.*
The trust has a similar profile of deliveries in terms of single or multiple births when compared to the England average.

The number of births for mothers aged 20-34 is higher at the trust than the England average. During the reporting period, 79.5% of mothers were aged 20-34 compared to an England average of 74.9%.

The number of births for mothers aged 35 and over is lower at the trust than the England average. During the reporting period, 16.7% of mothers were aged 35 and over compared to an England average of 22.1%.

### Gestation periods (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>209</td>
<td>9.2%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,067</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded (24 - 42 weeks only)**

| Total | 2,276 | 497,291 |

*Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

This table includes deliveries with a gestation period of 24 - 42 weeks only. Deliveries with a valid recorded gestation period of under 24 weeks or over 42 weeks have been excluded from this table due to low numbers.*

(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.

Number of deliveries at Tameside and Glossop Integrated Care NHS Foundation Trust by quarter

![Bar chart showing the number of deliveries by quarter from 2016/17 Q1 to 2018/19 Q1.]

The number of deliveries at the trust fluctuated between 528 and 614 per quarter during the reporting period.

(Source: Hospital Episode Statistics - HES Deliveries (July 2017 - June 2018))
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety</td>
<td>89</td>
<td>90</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>87</td>
<td>90</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>87</td>
<td>90</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>87</td>
<td>90</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>84</td>
<td>90</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>83</td>
<td>90</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the trust had an overall mandatory training compliance rate of 95.7% for qualified nursing and midwifery staff. The 95% target was met for four of the six mandatory training modules for which qualified nursing and midwifery staff were eligible.

It should be noted that the training modules not meeting the target is due to only six or seven eligible staff not having completed the training, so the performance should be taken in context when dealing with low numbers.

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the trust had an overall mandatory training compliance rate of 94.9% for medical staff. The 95% target was met for three of the six mandatory training modules for which medical staff were eligible.
It should be noted that the training modules not meeting the target is due to only one or two eligible staff not having completed the training, so the performance should be taken in context when dealing with low numbers.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had improved compliance rates with training on how to recognise and report abuse, and staff knew how to apply it.

Safeguarding processes were used consistently by staff, and in line with trust policy, to keep adults and babies safe from avoidable harm. All the staff we spoke to were able to give detailed explanation of their duties in relation to safeguarding concerns. The staff we spoke with were able to explain examples that would constitute a safeguarding concern and how to report it. Staff knew who the safeguarding lead was.

If a safeguarding concern was identified by a member of staff then they would fill in a safeguarding reporting form which would identify the level of risk and appropriate action to be taken such as a referral to children’s services, a pre-birth risk assessment or conduct a joint visit with the health visiting team. These were all reviewed and actioned by the safeguarding midwife. The safeguarding lead midwife worked closely with the paediatric safeguarding lead nurse.

Staff were trained to level three in safeguarding children, which was in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare staff, intercollegiate document (January 2019) which states that all clinical staff working with children who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a child or young person should be trained to Level 3.

The safeguarding lead midwife carried our quarterly safeguarding supervision sessions for community midwives and a minimum of yearly safeguarding supervisions for staff based in the acute service.

Safeguarding training including training in recognising and responding to female genital mutilation, domestic violence risks and child sexual exploitation. There was a group of domestic violence ‘champions’ across the maternity service and any concerns about a mother or baby’s welfare due to domestic violence risks would be referred to the enhanced care team for additional support and oversight.

The service had processes in place to flag when a woman had children subject to a child protection plan. We saw there were clear stickers on the front of women’s care records to indicate where there was a child protection plan in place. This provided contact details for the woman’s social worker and in the records, there was a full care plan for the woman and her unborn baby.

There was evidence of information sharing about safeguarding risks with community nurses and health visitors and the child’s GP postnatally through paper records and electronically. Children’s services sent a list of all children and unborn children subject to a child protection plan to the safeguarding midwife weekly. Child protection risk assessments would be done as early as possible and on a continuous basis so that a child protection plan could be established prior to birth if required.

The trust had an up to date abduction policy in place and staff were aware of it.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.
A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for qualified nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 4</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>85</td>
<td>90</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the trust had an overall safeguarding training compliance rate of 95.6% for qualified nursing and midwifery staff. The 95% target was met for two of the three safeguarding training modules for which qualified nursing and midwifery staff were eligible.

It should be noted that the training module not meeting the target is due to only five eligible staff not having completed the training, so the performance should be taken in context when dealing with low numbers.

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity the trust had an overall safeguarding training compliance rate of 92.3% for medical staff. The 95% target was met for one of the two safeguarding training modules for which medical staff were eligible.

It should be noted that the training module not meeting the target is due to only two eligible staff not having completed the training, so the performance should be taken in context when dealing with low numbers.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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 inspected were visibly clean. All equipment we inspected was visibly clean and labelled to show when it was last cleaned. The service used an external contracted cleaning service and we saw cleaning being carried out frequently throughout our inspection.

Staff used personal protection equipment (PPE) such as disposable gloves and aprons which was readily available in all areas. Staff were bare below the elbow and performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public.

The service used a quarterly comprehensive IPC audit tool to assess cleanliness of specific areas including general ward environment, clinical and treatment rooms, and the dirty utility areas. This was overseen by the trust IPC team and there was a link in the electronic report to a
comprehensive action plan to address any issues and whether this was the responsibility of the domestic team or ward staff. Any significant issues or themes were shared with ward staff at handovers and via email.

We reviewed the results for the audit from November 2018 and saw there was an overall compliance of 96%. Where areas had achieved lower than the target compliance of 95%, there were specific reasons given. For example, the kitchen areas in this audit had scored 77% due to fridge vents requiring cleaning and wall damage above the sink. The maternity theatres had scored 86% in the October audit which was below target and identified as non-compliant. There were key actions to address this, notably in relation to the staff shower/locker room and we saw that when the general environment had been re-audited this had scored 100%. At the time of our inspection we did not find these issues to still be flagging and service leads were aware of the key areas for IPC within theatres and how they were ensuring staff compliance.

Hand hygiene audits were completed monthly by ward managers. This involved staff being observed washing their hands after contact with women and ensuring staff were washing their hands according to the National Institute for Health and Care Excellence (NICE) guidance on effective hand decontamination.

The service monitored the instance of C.difficile and Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infections acquired by women when using the service. All women were screened for MRSA at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms.

Sharps boxes for the disposal of needles were assembled, clearly marked, within fill limit, signed and dated.

**Environment and equipment**

The environment was designed and managed in a way that kept people safe, although the maternity unit was undergoing significant redevelopment and renovation at the time of our inspection. Equipment was well maintained and sufficiently available for staff to safely treat women.

The maternity unit comprised the labour ward, combined postnatal and antenatal ward, delivery suite and antenatal clinics which were accessed separately.

The wards were securely locked with a buzzer system for both entry and exit to ensure the safety of women and babies. There was CCTV at the entrances which linked to a screen at the nurses’ station so staff at reception could see who was approaching the ward before buzzing them in.

The maternity ward (ward 27) had 25 inpatient beds including seven side rooms, used for post antenatal and postnatal care.

The service’s consultant-led delivery suite had six birth rooms including one with a water birth pool. The theatre was easily accessed on the delivery suite and the neonatal unit was nearby for timely transfers when required. If additional theatre capacity was needed the service would transfer to the trust main theatres.

The service was in the process of developing their midwifery-led birthing unit which was to be placed adjacent to the existing maternity unit. During our inspection they also had work taking place to refurbish the postnatal ward. This was due to be ready for use in summer 2019.

There were systems and processes for ensuring adequate access to equipment and the cleanliness and maintenance of equipment. We checked a range of consumables in each area and saw they were all stored appropriately and in date. Electrical items of equipment were also stored appropriately and had evidence of being within safety testing date. Staff on the labour ward
and postnatal ward confirmed they had no issues with access to equipment when they needed it or replacing equipment when required.

Every room on the labour ward had a cardiotocography CTG machine. There was a replacement scheme underway at the time of our inspection for new CTG machines to be introduced.

Baby resuscitaires (a specialist piece of equipment that is used for babies who may need some help with their breathing at birth), were available in every room within the delivery suite and were fully stocked, clean and ready for use.

Community midwives had access to essential equipment such as baby scales, sonic aids, and blood pressure machines with multiple sized cuffs. If midwives needed to measure the amount of bilirubin in the blood, they could take blood samples and bring them into the hospital laboratory for testing. The amount of bilirubin in the blood is a measure of jaundice in newborn babies.

Community midwives we spoke with reported it was easy to restock any equipment they needed themselves at the trust or report any faulty equipment.

There was a specialist bariatric theatre table to meet the needs of women over 200kg in weight.

There was no dedicated milk kitchen on the maternity ward but there was a dedicated milk fridge within the kitchen on the ward and this was locked. The fridge temperature had not been checked that day, but all other daily checks had been documented for the last month.

Resuscitation trolleys were checked daily to ensure they were sealed securely, and the security tag had not been tampered with. We saw the daily checks had been consistently carried out and signed off in each area. The midwife carrying out the checks would not check the contents, however the expiry date of the first item of the trolley to expire was printed clearly on the outside of the trolley and when it was approaching expiry the trolley would be returned to the resuscitation team who were responsible for restocking a new trolley. This was in accordance with trust policy.

We requested to break the seal of the trolley in the maternity ward and check the contents of the trolley. The service was able to do this because they had a backup resuscitation trolley in the storage area. The contents all matched the required list of items and were labelled with expiry dates and in date.

The service also had a post-partum haemorrhage kit which was sealed and labelled, and this was checked daily and signed off as part of the daily checks.

Assessing and responding to patient risk

There were systems and processes to manage and escalate patient risk in a timely way.

A range of risk assessments were completed during antenatal clinics during pregnancy and then on the maternity ward when a woman was admitted. All women had a domestic violence screening assessment carried out and if they were considered at risk this was highlighted by a green sticker on the front of the records and this was then shared with the health visitor team. All women were screened for mental health difficulties. The service had an enhanced care team and a range of enhanced care pathways for women and babies who were identified as being high risk.

In all five records we reviewed on the maternity ward, Modified Early Obstetric Warning Scores (MEOWS) were clearly documented. MEOWS is a screening tool intended to improve the response to a physiological deterioration in the pregnant woman. Staff were confident with the escalation process when a woman was scoring as high risk on the MEOWS. The MEOWS included a sepsis screening tool and we saw sepsis screening was carried out in the records we reviewed.
MEOWS audits were carried out monthly using a random sample of 10 sets of notes. We reviewed the audit results from February 2019 and saw that there was 100% compliance in accurate calculation of MEOWS, and that in accordance with policy all patients had their MEWS score recorded and all MEWS charts had the correct patient ID affixed. However, in comparison to previous audit a reduction was noted in eight of the eleven criteria; notably the recording of respiratory rate, heart rate, blood pressure and temperature, which reduced from 100% in the previous audit to 90%. There was also a decline in compliance with escalation in line with trust policy from 100% to 83%.

There was an action plan to address these aspects which included sharing the results in team daily huddles and emphasising the need to record all appropriate vital signs correctly; ensure that the frequency of observations and ensure the appropriate escalation of deteriorating patients was in line with trust policy.

Babies on the delivery suite and postnatal ward were monitored using the Newborn Early Warning Scores (NEWS).

The service had a process in place to ensure that babies had their NHS newborn and infant physical examination (NIPE) screening within 72 hours of birth. The NIPE screening test is a process to check if the newborn baby has any problems with their eyes, heart, hips and genitalia. The service monitored the online NIPE system daily and used the Red-Amber-Green rating system to check whether babies had or had not yet been screened. If a baby had to be discharged home without NIPE being carried out, they would always have oxygen saturation measurements taken prior to discharge. Midwives on the unit and in the community received training in NIPE screening.

We saw evidence the ‘fresh eyes approach’ had been adopted in the interpretation of cardiotocography (CTG). CTG monitoring was used to monitor the foetal wellbeing for women that were assessed as being high risk. Staff performed hourly reviews with a colleague to ensure ‘fresh eyes’ during labour. This was in line with guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG) on improving foetal monitoring (Every Baby Counts report, 2015). This was audited as part of the service’s quality standards and the last audit found that out of 20 CTG records checked, two did not have the ‘fresh eyes’ documented. Out of eight suspicious results identified in this sample, all had been subject to a second opinion in line with guidance and trust policy.

Within obstetric theatres, we saw good staff awareness of the World Health Organisation (WHO) ‘Five steps to safer surgery’ surgical safety checklist. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient’s intraoperative care pathway that is used for each individual patient undergoing a procedure within the theatre environment.

The service completed WHO checklist audits for obstetric theatres annually with the last one being fulfilled in August 2018. We reviewed the results of this which showed 100% compliance with the key standards of completing the WHO checklist. This was an improvement from the previous inspection and the service’s own previous audits where there had been poor compliance identified in WHO checklist audits. Although there were no actions to improve compliance, it was emphasised following this audit that staff should be acknowledged for the full completion and compliance and theatres leads should encourage this standard to be maintained. The next audit was scheduled for June 2019.

The assessment and triage area had a red, amber or green (RAG) rating system to determine whether women needed to be escalated to the delivery suite. This meant that women who were in
advanced stages of labour or deemed high-risk were prioritised by the service. The service did not have a high dependency unit for women on the labour ward. Women who became seriously ill were transferred to the trust’s critical care unit.

Pregnant women who were admitted to other areas of the trust for a separate condition, injury or illness were always reviewed by an obstetric consultant or registrar to assess risk from an obstetric perspective. The information about these patients and where in the hospital they were located was on the board in the maternity ward so that the team could ensure oversight.

The service ran an obstetric bleep test call every morning and night to ensure bleeps were working for an emergency.

Staff were trained in basic life support (BLS) and immediate life support (ILS). Training rates were 92.1% for BLS and 87.5% for ILS, although these rates were for women’s services as a whole so we could not break it down to just maternity staff.

**Midwifery and nurse staffing**

**Planned vs actual**
The trust reported the following qualified nursing and midwifery staff numbers for the two periods below for maternity:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nursing and midwifery staff</td>
<td>90.1</td>
<td>96.1</td>
</tr>
<tr>
<td></td>
<td>95.4</td>
<td>97.5</td>
</tr>
</tbody>
</table>

The trust reported a qualified nursing and midwifery staffing level of 93.7% in maternity from April 2017 to March 2018. This increased to 97.9% from April to November 2018.

From April to November 2018, there were 2.1 fewer WTE staff in post than planned for and 5.3 more WTE staff in post than from April 2017 to March 2018. There was an increase of 1.4 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The service used the BirthRate+ criteria and calculation tool in line with guidance from the National Institute of Health and Care Excellence (NICE) to ensure midwifery staffing numbers and skill mix was always sufficient to meet women’s needs and the acuity of the unit and reported on this monthly through the maternity dashboard. The service used the information to plan staffing for the following month. As of December 2018, the number of midwives required based on 2,368 births in the previous twelve months was 86.05 whole time equivalents (WTE), excluding managerial and non-clinical posts.

The service used a system of ‘staffing red flags’ in line with guidance from NICE (NG4, Safe midwifery staffing for maternity settings). This was checked and completed by the manager of the day. Red flags are signs that there may not be enough midwives available and include ‘after giving birth, a woman has to wait for 60 minutes or more before she is washed or given stitches, if she needs them’; ‘a woman does not get the medicines she needs when she’s been admitted to a hospital or a midwifery-led maternity unit’; and ‘a woman has to wait 30 minutes or more to get pain relief when she’s been admitted to a hospital maternity unit or a midwifery-led maternity unit’.

Results from February 2019 showed the service was compliant against the red flags.

**Vacancy rates**
From December 2017 to November 2018 the trust reported an overall vacancy rate of 6.5% for qualified nursing and midwifery staff in maternity. This was higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of our inspection, the vacancy rates had reduced and the service had a vacancy of 1.5 whole time equivalent for registered midwives. The service was proactive about filling vacancies. There was an active rolling recruitment programme and initiatives to attract applications and service leads told us their last vacancies advertised had received a lot of applications.

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 11.0% for qualified nursing and midwifery staff in maternity. This was lower than the trust target of 12%.

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

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 7.7% for qualified nursing and midwifery staff in maternity. This was higher than the trust target of 4.2%.

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

During our inspection, we discussed this with the head of midwifery. They told us there had been an issue with sickness among community midwives and felt this had been in part due to some leadership and culture issues which they had been working to improve and were starting to see an improvement in sickness rates as a result.

Bank and agency staff usage

From December 2017 to November 2018 the trust reported 7,237.3 of the 49,510.5 available hours were filled by bank staff (14.6%) and no hours were filled by agency staff in maternity. There were 11,509.7 hours that needed to be covered by bank or agency staff but were left unfilled (23.2%).

The trust gave the reason of ‘vacancies' for the usage of bank and agency staff.

A breakdown of bank and agency usage by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>December 2017 to November 2018</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td></td>
<td>5,509.2</td>
<td>16.1%</td>
<td>0.0</td>
<td>0.0%</td>
<td>8,987.7</td>
<td>26.2%</td>
<td>34,261.5</td>
</tr>
<tr>
<td>Non-qualified</td>
<td></td>
<td>1,728.1</td>
<td>11.3%</td>
<td>0.0</td>
<td>0.0%</td>
<td>2,522.0</td>
<td>16.5%</td>
<td>15,249.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7,237.3</td>
<td>14.6%</td>
<td>0.0</td>
<td>0.0%</td>
<td>11,509.7</td>
<td>23.2%</td>
<td>49,510.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

By the time of our inspection there was less use of bank staff due to filling midwife vacancies. Service leads told us they relied mainly on regular in-house bank staff who were familiar with the ward and the team. The service did not use agency staff.

Midwife to birth ratio

From July 2017 to June 2018 the trust had a ratio of one midwife to every 22.87 births. This was lower (better) than the England average of one midwife to every 25.48 births for this specific time period.
At the time of our inspection in March 2019 the midwife to birth ratio was one midwife to 27.5 births. This was better than the national standard which was 1:29.

Medical staffing

Planned vs actual

The trust reported the following medical staff numbers for the two periods below for maternity:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Medical staff</td>
<td>15.0</td>
<td>27.5</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 54.6% for medical staff in maternity from April 2017 to March 2018. This dropped to 49.8% from April to November 2018.

From April to November 2018, there were 14.0 fewer WTE staff in post than planned for and 1.0 less WTE staff in post than from April 2017 to March 2018. There was an increase of 0.5 WTE planned posts between the two time periods.

At the time of our inspection medical staffing in maternity had improved significantly and the service was meeting its planned levels. Midwives consistently told us they could access medical review promptly when they needed to and on the days of our inspection we saw there were enough numbers and skill mix of medical staff to meet the acuity of patients.

The service was compliant with Royal College of Obstetricians and Gynaecologists (RCOG) recommendations on consultant presence in the labour ward (Safer Childbirth report). There was 60 hours a week of consultant presence to meet women’s needs in accordance with the service’s number of births. There were consultant led ward rounds every day including weekends and two resident night shifts by consultants during the week. Compliance was monitored by a monthly submission to the RCOG.

There was an on-call rota for out of hours anaesthetic cover to ensure there was 24 hour cover from a consultant anaesthetist.

Medical handovers were conducted at 9am, 1pm and 5pm daily. We observed a medical handover on labour ward which was attended by consultants, junior doctors and the anaesthetist on shift. There was also a midwife present at each handover to ensure midwifery and medical staff were aware of the same information and worked together. All relevant information was discussed to ensure women and babies were kept safe including comprehensive discussion of women at high risk.

Vacancy rates

From December 2017 to November 2018 the trust reported an overall vacancy rate of 46.9% for medical staff in maternity. This was higher than the trust target of 4%.

At the time of inspection in March 2019, the vacancy rates had improved significantly. As of March 2019, the medical staff vacancy rate was 4%, although this was for obstetrics and gynaecology combined. The trust had recently appointed two additional consultants which had helped
consultant presence and continuity of care and support for junior doctors. However, there were still vacancies for middle grade doctors which service leads told us they were finding it difficult to recruit to.

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 0.0% for medical staff in maternity. This was lower than the trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) - Turnover tab)*

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 2.47% for medical staff in maternity. This was lower than the trust target of 4.2%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

From November 2017 to October 2018 the trust reported 87.9 of the 58,396.8 available medical staff hours were filled by bank staff (0.2%) and 5,820.0 hours were filled by locum staff (10.0%) in maternity services at Tameside General Hospital. In addition, there were 5,907.0 hours that needed to be covered by bank or locum staff but were left unfilled (10.1%).

The trust gave the reason of ‘vacancies’ for the usage of bank and locum staff.

A breakdown of bank and locum usage is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Tameside General Hospital</td>
<td>87.9</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)*

We reviewed this on inspection and found there had been improvement in the use of locum staff by March 2019. The trust was still reliant on locum staff to cover unfilled shifts in maternity, but locum staff were regular in the service and familiar with the team and service.

There were no locum staff on the days of our inspection, but we were told by midwives and medical staff that locum staff were considered part of the core team and were familiar with the service.

**Staffing skill mix**

In September 2018, the proportions of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England averages.

**Staffing skill mix for the 29.3 whole time equivalent staff working in maternity at Tameside and Glossop Integrated Care NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>50%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Records were stored securely.

Records were stored securely in all areas. Although they were not in locked records trolleys, the records trolleys were kept behind the nurses’ station away from general access. This was an improvement from our previous inspection where it had been a concern that records were not stored securely as they had been in the main thoroughfare of the ward in an unlocked trolley.

On ward 27 they were in the process of undergoing a refurbishment which would further improve the security of records, by installing a screen and hatch at the front of the nurses’ station so that records trolleys were physically closed off.

We reviewed a sample of five records of women who were still on the ward at the time of inspection and found them to be contemporaneous, legible, dated and signed. All staff were issued with an individual stamp with their name and NHS number to use in records to improve clarity. At a handover we observed in the antenatal clinic, the nurse in charge reminded all staff that if they had lost their stamp to request a new one and to ensure their name was printed legibly on the records.

All records had risk assessments carried out at booking and a venous thromboembolism (VTE) risk assessment was completed for each person admitted to the maternity unit. There were clear CTG stickers in records to indicate clearly that CTG checks had been done hourly. This was in line with guidance from the National Institute of Health and Care Excellence (NICE).

Women’s choices and preferences were documented clearly and information regarding prescription medication, alcohol intake, medical history and additional needs was completed fully.

On discharge home, an electronic summary was immediately posted to the GP and health visitor team to hand over care to the appropriate health professionals.

Although there was no formal records audit taking place in the service, the service carried out documentation reviews as part of the twice weekly multi-disciplinary incident review panel in the service. We were told that feedback was provided to individuals relating to good standards of documentation or concerns raised from the reviews.

(Source: NHS Digital Workforce Statistics)
Ward managers carried out documentation spot checks on the ward and fed back to individuals at the time. However, this was difficult to quantify because this was a verbal process which meant there was not clear tracking of documentation standards month by month to identify improvement or worsening. There was also a risk that key messages would not be shared with the wider team, only the individual.

Despite this, there was good awareness of standards of record keeping in the service; for example, a consultant in the antenatal clinic explained how documentation of VTE assessments had been identified as an issue so the service was focusing on including reminders in handovers and ensuring staff were aware of the importance of documenting it.

**Medicines**

The service followed policy, national guidance and best practice when prescribing, giving, and storing medicines, although we identified concerns in relation to the storage and tracking of medicines to take out.

We reviewed five completed prescription charts and saw they were clear, up to date, signed off and identified women’s specific needs. Allergies and weights were documented clearly.

We had concerns about the storage and tracking of medicines to take out (TTOs) in the maternity ward (ward 27) because there was a basket of various medicines of different amounts and from different packets stored in the locked drugs cupboard on the ward.

It was not clear what these were for and when we asked, the midwife in charge explained that when women were prescribed antibiotics or other TTOs, the service would give only the exact amount for the number of days they had been prescribed to take them and would cut off and discard any additional doses in the pack. These additional doses would then go into the basket and be picked up by pharmacy weekly when pharmacy restocked and be taken back to the trust pharmacy stores for checking. They would not be added to new packets or go back onto wards, but this was not in line with local policy and best practice whereby the full packet of antibiotics should go with the patient and not be altered.

We raised this with the trust at the time of our inspection and they immediately addressed it by removing the basket and sharing reminders with the staff on the ward. This was also included in the handover the next morning. Other than this, all medicines including controlled drugs (CDs) were stored appropriately and securely and were in date.

TTOs were recorded on the trust electronic system. Two midwives together would check the prescription and dispense the medication from the medicines room on the ward and print the record. One copy was given to the patient, one was put in the woman’s paper care records and one was sent to pharmacy for them to know how much to restock.

The maternity unit did not have a pharmacist dedicated to the unit, but staff confirmed they were able to access pharmacy support when they needed it. Pharmacist notes were documented in purple in each woman’s records, so they were easy to identify at a glance.

The service had identified a theme in delayed antibiotics which was on their risk register. To address this, they had increased the numbers of midwives trained in administering antibiotics from three to 16 midwives on the ward and had scheduled a date for a second cohort of training later this year.

The service worked in line with national guidance on antibiotics administration and management, including NICE Quality Standard 61: People are prescribed antibiotics in accordance with local antibiotic formularies, and NICE Quality Standard 121 statement four: People in hospital who are
prescribed an antimicrobial have a microbiological sample taken and their treatment reviewed when the results are available.

The service was in the process of developing a patient group direction (PGD) for the administration of medicines to treat postpartum haemorrhage. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This was following an incident of cardiac arrest due to postpartum haemorrhage earlier in 2019.

There were no midwife prescribers in the service. However, midwives reported consistently good access to pharmacist support when needed and to doctors to prescribe.

Community midwives did not carry medical gases in their cars. If oxygen was required, it would be signed over for a pharmacist to transport it directly to the midwife requiring this. This was in line with trust policy. All four community midwives we spoke with said they had no issues accessing oxygen when needed.

**Incidents**

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.

Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses. There was a good culture of incident reporting and staff understood how to report an incident and where to locate the trust policy on incident reporting. Incidents were reported through the trust electronic incident reporting system. Staff could give examples of learning from recent incidents.

The service was proactive about responding to incidents quickly. Service leads gave the example of a cluster of incidents occurring in January and February 2019 in relation to increased numbers of babies having low weights recorded on community visits and being readmitted to the trust as a result.

We requested the numbers of babies readmitted for this reason and the service informed us there had been five incidents of this type. When this pattern was investigated it was found there was a batch of weighing scales allocated to community midwives that had not been calibrated properly and were giving inaccurate readings. These were immediately replaced. The service also identified that the pathway for managing and escalating baby weight before and after discharge was not clear so did some work to clarify it and communicate this to midwives.

Learning from incidents was shared by email, in daily ward safety huddles, medical and midwifery handovers and newsletters. Feedback for staff directly involved in incidents was shared through outcome reports sent by email.

The service had midwife ‘champions’ for sharing learning from incidents in the community team as they were more isolated when working, to ensure information was consistently shared. The service worked collaboratively with eight other trusts in the region with a maternity ‘safety champion’ from each trust to share learning from incidents regionally and bring external learning back to the service.

The clinical quality lead midwife reviewed themes and trends and learning from incidents in relation to the previous year to ensure that actions and learning were still being continued and that progress following incidents was continued in the long term.
The evidence based practice group also reviewed recent incidents at their monthly meetings to consider whether practice could be improved. When an incident resulted in a subsequent coroner’s inquest, there had been examples of when a member of the coroner’s team and/or legal team attended briefings with staff involved in the incident to share learning with them and to help them understand what to expect if they were being asked to give evidence.

Staff knew what the duty of candour was. The duty of candour applies to registered professionals and provides that staff must be open and honest with service users and other relevant persons, when things go wrong with care and treatment, giving them reasonable support, truthful information and an apology. There had been six applications of the duty of candour between December 2017 and November 2018 in the service.

**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.

From December 2017 to November 2018, 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 10 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major incident / emergency preparedness, resilience and response/suspension of services</td>
<td>8</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>1</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Eight incidents related to the maternity unit either being closed or diverted due to reduced organisational capacity to provide clinical services or midwifery staffing shortages.

(Source: Strategic Executive Information System (STEIS))

There were appropriate actions taken following this theme of unit closures. This included reviewing the escalation policy and procedure, improving the weekend staffing cover and closer working with the trust senior team and board to escalate risk at the earliest stage.

**Safety thermometer**

Staff collected safety information and shared it with staff. The safety information was reviewed and used to improve aspects of safety and quality.

The trust made the decision to stop completing the Safety Thermometer figures for the Maternity Services dashboard in December 2018. The last information submitted was for October 2018. The
service now used a tailored Measures Dashboard which was developed by the service to measure over 60 indicators relating to caseload, clinical care, neonatal mortality, risk management and complaints. This dashboard included monitoring of the number of major haemorrhages, emergency caesarean sections, inductions, and readmissions to hospital. This was reviewed at local and divisional clinical governance meetings, with key messages and actions being fed back to staff through huddles and emails.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and showed evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service monitored compliance with national guidance and standards including from the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). The service’s clinical lead was responsible for reviewing the new NICE guidance and assessing relevance, conducting an organisational gap analysis of current practice against the recommendations and identifying shortfalls as required. The clinical lead was responsible for confirming the compliance status and any associated risks.

The service had appropriate and up to date local guidelines and the authors of these were notified in advance when they were due to expire. The service had a dedicated evidence-based practice working group which focused on challenging practice, reviewing new guidelines and recommendations and assessing the best ways to implement best practice and national standards into their service. This was multidisciplinary and helped encourage all staff to have a role and responsibility in maintaining best practice and challenging poor practice. Guidelines were easily accessible on the trust intranet for staff to access.

The service was working in accordance with the NHS ‘Saving Babies’ Lives’ care bundle. Saving Babies’ Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice – smoking cessation, risk assessment for foetal growth restriction, surveillance and awareness of reduced foetal movements, and effective foetal monitoring during labour. There was a dedicated clinical lead to implement the programme and a team of maternity safety champions to ensure it remained embedded in staff practice.

The service was performing well in relation to Saving Babies Lives. They were one of the top ten maternity services in the country for detection of foetal growth restriction (FGR). Between January and June 2018 there were no still births directly attributable to FGR.

The service participated in the Growth Assessment Protocol (GAP) and training was included in induction for midwives and doctors. GAP is a means of monitoring FGR referral and detection rates, and regular audits of FGR cases not antenatally detected to help identify issues. The GAP programme has resulted in significant reductions in stillbirths in each of the NHS regions where it was widely implemented and has been associated with recent year on year drops in national stillbirth rates in England.

Women accessed antenatal appointments in line with the NICE Antenatal Care Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy in all settings that provides routine antenatal care. This includes primary, community and hospital-based care.

There was a comprehensive local audit schedule. This included audits of completion of cardiotocography (CTG) stickers and CTG ‘fresh eyes’ completion, modified early obstetric warning score and the Gestation Related Optimal Weight (GROW). Grow charts plot the fundal height and estimated foetal weight of a baby to monitor its development. We saw that the audits identified areas for improvement and actions to be taken.

The service had a clinical audit team to ensure they were assessing and monitoring aspects of their service and to act on areas of concern. All staff were encouraged to be involved in audits and each audit was supervised by either a consultant or a senior midwife. We spoke with one
consultant who was a lead in this and they felt there was good engagement from all staff about auditing the service. The team had monthly meetings to discuss results of audits and identify actions for improvement to be shared by the leads among teams through huddles, handovers and email.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs.**

Women’s nutrition and hydration needs were documented in their records. All women we spoke to at the time of inspection said their nutrition and hydration needs were met.

The maternity service had previously achieved UNICEF Baby Friendly Initiative (BFI) Level 3. This is a worldwide initiative to promote healthier feeding practices and improve standards of feeding for all babies. However, the service had let the accreditation expire. The service was waiting for the midwifery-led care unit to be in place before reapplying for their BFI accreditation.

There were pathways in place to ensure tailored and safe care was provided for women with diabetes and bariatric women. There was a lead consultant for bariatric pregnancy and there were specialist diabetes antenatal clinics one day a week.

There was an infant feeding team of one lead and two additional midwives to support mothers with feeding.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Women had a choice of pain relief and they could use the birthing pool if assessed as a low risk pregnancy. Women had the option to use nitrous oxide and oxygen mixture (Entonox) gas, intra muscular opioid injections and epidurals in accordance with national guidance NICE CG190 Intrapartum care 2017.

The service audited the time taken between requesting and receiving an epidural. The average time between November 2017 and October 2018 was 13.5 minutes, which was better than the national target of 30 minutes.

The service was in the process of introducing a hypnobirthing service and aromatherapy as alternative or additional tools to help women during labour.

All women we spoke with told us their pain was managed well by the service and they had been offered pain relief and did not have to wait to receive it.

**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 service used the national Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard. At the time of our inspection, the service was achieving 100% compliance with their reporting requirements to PMRT. The PMRT is used to help staff understand why a baby has died and whether there are any lessons to learn from the death to save future lives. It also includes ways of involving parents in the review.

The service held perinatal mortality meetings every two months together with the paediatric consultants and there was evidence of learning from mortality reviews to improve outcomes. For
example, we reviewed the minutes from the January meeting and saw a comprehensive review of a mortality case and learning identified, such as the need to inform a paediatrician at the earliest opportunity in the event a baby has meconium. Positive practice was also identified and shared, including for example that the woman received appropriate antenatal and delivery care. This information was shared with teams and at medical handovers as a means of improving outcomes.

There was a maternity dashboard based on guidance from the Royal College of Obstetricians and Gynaecologists (RCOG, Good practice No.7).

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit Tameside General Hospital performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 65 eligible cases identified for inclusion, 86.2% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital met the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were seven eligible cases identified for inclusion, 14.3% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

  This was lower than the national aggregate of 43.5% and put the hospital in the bottom 25% of all units.

  *(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

  We reviewed the underperformance in the magnesium sulphate measure with the head of midwifery during inspection and found this had improved to 100% compliance by March 2018. The improvement was achieved by issuing reminders to staff about ensuring the mother’s full history was clear in the records, to ensure it was clear when babies were below 30 weeks gestation and by implementing a collaborative approach between the assessment and triage area and the labour ward.

**Standardised Caesarean section rates and modes of delivery**

Between April 2017 and March 2018, the total number of caesarean sections was similar to expected.

The standardised caesarean section rates for both elective sections and emergency sections were similar to expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>276</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>350</td>
</tr>
</tbody>
</table>
In relation to other modes of delivery from April 2017 and March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average.

The trust had a lower proportion of instrumental deliveries, a similar proportion of caesarean sections and a higher proportion of non-interventional deliveries when compared to the England averages.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>626</td>
<td>27.2%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>203</td>
<td>8.8%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>1,474</td>
<td>64.0%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,303</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^1\)Includes elective and emergency caesareans
\(^2\)Includes forceps and ventouse (vacuum) deliveries
\(^3\)Includes breech and vaginal (non-assisted) deliveries

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As at 8 February 2019, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.80.

This is up to 10% higher than the average for the comparator group rate of 4.79.

Performance was worse than expected when comparing this provider to other trusts with similar service provision.

(Source: MBRRACE UK)

When we reviewed mortality data at the time of our inspection in March 2019 we found there had been improvement to this but there was no updated MBRRACE audit data yet. The service’s ‘Saving Babies’ Lives’ programme had been embedded to improve outcomes.

Competent staff

Staff had the necessary competencies and skills to carry out their role. Staff were
supported in their development and progression.

There was a two-year midwife preceptorship programme. There was a team of five professional midwifery advocates (PMAs) who provided coaching and restorative supervision to midwives and supported them with revalidation. Midwifery staff knew who the PMAs were and felt they were supportive.

When new midwives joined the service, they had a two-week supernumerary period which could be extended if it was considered necessary. We were told this supernumerary period was always protected.

Midwives had assessments of their competence to complete and interpret cardiotocography (CTG) records. It was included in their appraisal that they had to complete five simulated exercises. To aid the competence with CTG interpretation these were reviewed at specific meetings and shift handovers, where multidisciplinary discussions could take place.

There were core staff who remained working in a specific area of maternity services who therefore had the expertise in that area. There were then staff who rotated between areas such as community and inpatient wards to keep up their skills.

For medical staff, the tutor met monthly with trainees for support and supervision. A junior doctor we spoke with in the antenatal clinic said they felt well supported, received sufficient time for training and were enjoying their placement.

We observed consultants communicating well with and supporting junior doctors; for example, in the antenatal clinic a consultant encouraged a foundation year two (FY2) student to give their suggestions on a patient’s clinic results. Junior doctors presented at daily handovers and at perinatal mortality meetings to help improve their competence with this.

Staff were trained in the use and recording of GROW. As part of their implementation of the Saving Babies’ Lives’ care bundle, midwives received annual training in effective foetal monitoring during labour.

Appraisal rates

From April to November 2018, 82.1% of required staff in maternity received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Individuals required</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing and midwifery staff</td>
<td>100</td>
<td>117</td>
<td>85.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other non medical staff</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Support to doctors and nursing Staff

<table>
<thead>
<tr>
<th></th>
<th>18</th>
<th>26</th>
<th>69.2%</th>
<th>90%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>138</td>
<td>168</td>
<td>82.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

At the time of inspection, the service had improved their appraisal rates. They had recently improved their staffing which helped free up time for managers to hold appraisals. All staff we spoke with said they had received an appraisal in the last year and ward managers were on track with their appraisal schedules.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, midwives and other healthcare professionals, both internal and external to the service, supported each other to provide good care.

Staff of different types within the service worked well together. Both midwives and doctors said they had good communication with one another and worked as a team. We saw this taking place throughout our inspection.

There was good support from other areas of the hospital. For example, the service could access a paediatrician for support and to attend births where there were identified risks.

There were multidisciplinary learning days for staff from various specialities to share practice. The obstetrics and gynaecology doctors, nurses, midwives, anaesthetists, emergency department doctors and nurses were all able to attend.

The service had strong external links to maximise patient outcomes and share learning and information. For example, the service was active in a Greater Manchester maternity working group with the aim of reducing stillbirth rates by 50% through shared learning and best practice.

The Maternal Alcohol Management Algorithm (MAMA) service had links with other health professionals to provide varied and flexible support for patients including children’s centres, women’s refuge centres and the early help centre.

Where patients needed to be transferred to other units due to medical concerns, there were systems in place for the exchange of information. Midwives would travel with the patient and hand over their care to the receiving hospital.

The service worked closely with GPs, social services, local authorities and other agencies to ensure a collective approach to achieving effective care of women and babies. Midwives and doctors reported good external MDT working.

**Seven-day services**

Services were available that ensured care could be delivered seven days a week, including out of hours.

There was access to medical staff cover 24 hours a day with sufficient consultant cover in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG).

Staff had access to diagnostic services such as x-ray, ultrasound, computerised tomography (an imaging procedure that uses special x-ray equipment to create detailed pictures, or scans, of areas inside the body), echocardiography (a sonogram of the heart) and pathology when needed.

Staff reported sufficient support from pharmacists when required, seven days a week.
Community midwives provided a seven-day, 24-hour home birth service. Sonography was available in the antenatal clinic between 8.50am and 5pm, Monday to Friday.

**Health promotion**

**The service had initiatives and processes to involve people in the management of their own health and supported them to do this.**

There were initiatives for health promotion in the service. The service had a smoking cessation midwife and had adopted a ‘Baby Clear’ initiative with support from the clinical commissioning group (CCG) for additional funding for a second part-time smoking cessation midwife. The area had high rates of smoking in pregnancy compared to the national average but had managed to reduce rates from 20% to 14% and were focusing on improving this further through outreach and community smoking cessation support.

The service had an intervention plan for smoking in pregnancy as part of the implementation of the ‘Saving Babies’ Lives’ care bundle, which included carbon monoxide testing for all pregnant women and a clear referral pathway to smoking cessation services, including regular feedback and follow up.

Women booking for maternity care were screened as part of the service’s Maternal Alcohol Management Algorithm (MAMA) pathway and women identified at risk were offered support from the enhanced midwifery team and referral to specialist services to support abstinence. The service was achieving 100% compliance with screening all women and had measured an average of 85% reduction in harmful drinking between the booking appointment and the repeat screen at 16 weeks.

There was a ‘baby books’ scheme which was run in conjunction with the local council, where baby books were provided for new mothers to take home with them as an initiative to encourage reading from an early age.

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

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

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

The trust set a target of 80% for completion of mental capacity act (MCA) training.

From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 87.5% of eligible medical staff in maternity compared to the trust target of 80%.

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

At the time of our inspection in March 2019, the mental capacity act training completion rates for qualified nursing and midwifery staff in maternity were 95.9% which was above the trust target. Midwifery staff also undertook focused training on the Learning Disabilities in Pregnancy Pathway which included MCA and used scenarios for learning using real examples of MCA issues.

There were three Safeguarding Adult Managers in maternity who had all completed specific comprehensive training relating to MCA/DOLs and could provide support for staff to manage any
difficult situations. During inspection we saw good awareness and compliance with the principles of consent and mental capacity.

**Is the service caring?**

**Compassionate care**

**Staff were caring and compassionate in their interactions with women and families. Women felt they were well cared for.**

We spoke with five women who had given birth. They all gave positive feedback about the care they had received during their stay. For example, one patient said that they had been anxious, and all staff had supported and reassured them. They particularly praised the theatre staff.

Another patient described the midwife and student midwife who were delivering the baby as ‘fantastic’. One woman we spoke with in the antenatal clinic said she had used the service several times and was very happy with her experience and described her consultant as ‘brilliant’.

We observed caring interactions between all staff and patients during our inspection and all staff displayed a clear patient focus.

**Friends and Family test performance**

Please note, no data for any setting is available for November 2017 from NHS England for any trust due to data quality issues. Antenatal data for April and August 2018 and postnatal community data from February to June 2018 was suppressed for this trust due to low response figures.

**Friends and family test performance (antenatal), Tameside and Glossop Integrated Care NHS Foundation Trust**

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

From October 2017 to October 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was worse than the England average in five months and better in four.

In July 2018, the trust’s performance dropped to 70% compared to the England average of 95%.

In February, March and June 2018, the trust's performance was 100% compared to the England averages of 97% or 96%.

The latest figures for October 2018 show the trust performance to be 88% compared to the England average of 95%.
Friends and family test performance (birth), Tameside and Glossop Integrated Care NHS Foundation Trust

From October 2017 to October 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally better than or similar to the England average.

In January, March and August 2018, the trust’s performance was 100% compared to the England average of 97%.

In June, July and September 2018, the trust’s performance dipped slightly below the England averages.

The latest figures for October 2018 show the trust performance to be 99% compared to the England average of 97%.

Friends and family test performance (postnatal ward), Tameside and Glossop Integrated Care NHS Foundation Trust

From October 2017 to October 2018 to the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally worse than the England average with a downward trend.

In May 2018, the trust’s performance was 100% compared to the England average of 95%. However, in the most recent five months, the trust’s performance has been worse than the England average. In August 2018, the trust’s performance was 67% compared to the England average of 95%.

The latest figures for October 2018 show the trust performance to be 85% compared to the England average of 95%.

Friends and family test performance (postnatal community), Tameside and Glossop Integrated Care NHS Foundation Trust
From October 2017 to October 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally better than the England average. In six of the months the trust’s performance was 100% compared to the England average of 98%. The latest figures for October 2018 show the trust performance to be 100% compared to the England average of 98%.

For the month of August 2018 there were zero responses reported by the trust, resulting in the drop in the chart.

(Source: NHS England Friends and Family Test)

We spoke with service leads about the fluctuating performance in FFT results. They had identified this as an issue and had implemented an action plan for improving response rates and positive responses. This included providing all community midwives with FFT cards and reminding midwives to encourage women and partners to give feedback.

The actions to address negative responses included improving administrative and clerical support to ensure better communication with women and development within the community team to better meet the needs of women; for example, extending their hours.

The service had recently recruited a head of patient experience and said they were seeing improvement in patient feedback and response rates.

**CQC Survey of women’s experiences of maternity services 2018**

The trust performed about the same as other trusts for all 19 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>Comparison</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>8.2</td>
<td>About the same</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>7.9</td>
<td>About the same</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>9.5</td>
<td>About the same</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>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
</tbody>
</table>
### Staff during labour and birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<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>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
</tbody>
</table>

### Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.4</td>
<td>About the same</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>7.5</td>
<td>About the same</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>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>5.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

### Emotional support

**Staff provided emotional support to women and families.**

The service had a specialist bereavement midwife. The bereavement midwife coordinated care for women and families in the event of a miscarriage, stillbirth or baby loss up to the first year of life. The service’s bereavement midwife could refer women and their partners for counselling sessions at home. There were additional midwives with specialist interest in bereavement support who also provided support for families.

The service ran a yearly chapel service at a local church for all women and families who had used the service and experienced a bereavement, which we were told was always well attended and appreciated by families.

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)
The service had links with bereavement charities and other organisations to refer women for additional support.

Women and families, we spoke with during the inspection said they felt their emotional needs were met and supported by staff.

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

During our observations of staff interactions with women and partners we saw that staff took the time to ensure patients understood what was being discussed with them.

Out of five patients we spoke with, four consistently reported they felt involved in their care, including during their antenatal appointments through to postnatal care. For example, one woman said they were ‘kept informed of everything’ and another felt everything went according to the expectations that were set by staff. One woman and her partner said they felt that involvement and understanding could be improved because they were not aware of what their individual care plan was and felt the time had not been taken to discuss it with them.

There were examples of initiatives to ensure and promote the understanding and involvement of women. For example, the community midwifery team offered home birth workshops to women and partners to help them understand what to expect prior to birth.

Service leads including the head of midwifery felt the service could improve their communication of information to women and partners and improve the management of expectations, as this had been identified as an issue. They were hoping to use their new service user forum and share reminders to teams on the ward to help with this.
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.

Women accessed maternity services through their GP practice or by using the service’s online booking form and could choose a consultant led birth, a midwifery led birth or a home birth dependent on suitability following a risk assessment.

There was evidence of the service considering the needs of the local population and planning or adapting their services accordingly to meet their needs. For example, the service had set up out of hours post-natal clinics at the trust so that women did not have to wait all day at home for their community midwife.

There was a care package offered to people who struggled to access the service which involved antenatal appointments at tertiary centres and increased use of community visits. This had been identified because the area had one of the lowest rates of car ownership in the country and bus routes were long.

The service had recently implemented a service user forum to obtain more feedback from women and families and ensure their views were reflected in the service planning and delivery of the service. They also took part in a regional maternity working group with other maternity services to design services to meet the needs of the local population.

Bed Occupancy

From April 2017 to September 2018 the bed occupancy levels for maternity were higher than the England average. The trust had 65.7% occupancy in Quarter 2 2018/19 compared to the England average of 59.6%.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

The service took account of women’s individual needs. The service worked in partnership with local organisations to ensure care was delivered and coordinated in a way that supported women with complex needs.

Staff assessed and identified the individual needs of women, including their cultural and social needs, birth preferences (for example on pain relief, positioning and the environment during labour), and mental health needs.

There was an enhanced care team of midwives who supported women with complex needs. This included mental health concerns, substance abuse issues and domestic abuse. Risk assessments to assess whether women required this additional support was done at the booking appointment, but women could be referred into the enhanced care team at any point during their pregnancy. There was a specialist mental health consultant obstetrician.

The trust had a ‘flagging and alert’ system for women with learning disabilities and/or autism spectrum conditions. This alerted the learning disability liaison nursing team when women with one of those conditions was admitted. Staff were aware of the learning disability team and could demonstrate how they would contact them using the trust’s intranet pages. The service did not have their own learning disability midwife, but the enhanced care team could provide support and work with the trust wide learning disability nurses to meet the needs of these women.

Service leads told us they worked closely with health visitors, social services and the police where necessary to meet the needs of vulnerable women and their babies.

The antenatal service provided a range of specialist clinics to help meet specific needs, including clinics for women with diabetes, bariatric women and vulnerable women. This team would also carry out community visits to provide support to women in their own homes.

There were initiatives to meet and promote individual needs and preferences. For example, the service had received approval to develop an aromatherapy workshop service which would be free for women to access. They were doing multidisciplinary work to communicate the benefits of this to both staff and families. Service leads were also carrying out research into the possibility of hypnobirthing.

There was a designated bereavement midwife who provided support for women and families who had experienced a stillbirth or baby loss. Cold cots and cuddle cots were available to extend the time families could spend with their baby including allowing babies to be taken home using the cold cots. Women were supported to make special memories for the baby they had lost.

There was a dedicated bereavement suite which provided a private space for women who had experienced a stillbirth or baby loss, and their families. This comprised a bedroom area and en-suite bathroom, a kitchen and a small patio area for outdoor space which could only be accessed through this suite so was only for private use by the woman and her family. This patio area had been designed and funded by a previous service user who had experienced a stillbirth. The service could arrange for catering to provide meals and refreshments directly to the bereavement suite and offered this to women.

We were told that, if there were two stillbirths on the ward at the same time, the service would allocate another specific side room to the woman and her family. This would be the first side room
upon entry to the ward which meant they did not need to go past other women and their families to access it.

The service could provide ‘baby bundles’ and cribs to mothers who were not able to purchase or access these resources themselves.

Staff could access trust-wide translation services and information was available in a range of languages. There was a range of useful information displayed on boards in the wards and on leaflets provided to women and families, such as information on skin-to-skin contact and breastfeeding.

**Access and flow**

**People could access the service when they needed it.** Waiting times were audited and acted upon and there was evidence of smooth and efficient flow through the service. Although the service had experienced a number of closures due to capacity and staffing, there was an escalation policy for this and evidence of actions to improve this.

Women were booked into the service by community midwives in GP surgeries in the local area. They would then have their booking appointment in the antenatal clinic at the 10-week stage. The service was working in line with National Institute of Health and Care Excellence (NICE) guidance [CG62] which recommends that women are booked into the service by 10 weeks.

The delivery suite, pregnancy assessment and triage unit were accessible 24 hours a day. Women who were assessed as being in labour were directed immediately to the delivery suite. Community midwives provided an on-call service for those women booked for a home birth.

The dedicated triage area of the maternity unit ensured women could obtain prompt telephone advice and be seen quickly. This operated from 7am to 7.30pm, and the out of hours it was moved to an area within the labour ward. This was always staffed by a dedicated triage midwife to ensure efficient access and flow. Once the midwifery led unit was in place all triage would always be completed in the unit.

Between November 2017 and October 2018 there was a monthly average of 2.2 births where a planned home birth had to be transferred to hospital. The monthly average for babies being born in transit on the way to hospital was 0.5.

We reviewed the service’s readmission rates for mothers and babies following discharge, from December 2018 to February 2019. The overall readmission rate for mothers for this period was 2 per cent, which equated to 11 readmissions. This did not include home births. The service identified reasons for readmission, which included puerperal sepsis, delayed postpartum haemorrhage and other postnatal complications. This data was reported monthly on the internal Maternity Dashboard and are also submitted externally on the Maternity Dashboard and Quality Improvement Data Collection Form for Greater Manchester and Eastern Cheshire.

For the same timeframe, there were 115 babies readmitted within 28 days of discharge, although this was not shown as a proportion of the total number of births during this time to assess the specific readmission rate.

At the end of 2018 there had been a theme identified in incident reports relating to missed postnatal visits in the community. There had been 36 incidents between March 2018 and February 2019. The service leads explained how they had reduced missed visits in the community by strengthening communication and support across community midwives. There were no missed visits in September and October 2018 and follow up visits were being monitored each month.
The service had a strict policy about not accepting outliers onto the unit (patients who were not pregnant and were under the care of other areas of the hospital), from which they never deviated.

The service had reduced their admissions to the neonatal intensive care unit by 15% in the last year, through an action plan which included improved foetal anomaly detection screening and awareness among staff. They had developed an enhanced pathway with input from paediatricians to help achieve this.

The service had high numbers of scans referred, so to ensure they could manage this in a timely way they had appointed a band seven midwife sonographer and two additional midwives had completed their sonography training to increase capacity and ensure efficient flow through the service.

The service offered both medical and mechanical induction of labour. The benefit of mechanical induction for low risk women was that they could return home after having the procedure and await signs of labour or return for reassessment the next day.

From November 2017 to October 2018, the median time for admission and delivery for all inductions at term was 28.7 hours. The service had high induction rates, for example the rate for February 2019 was 42%. This was significantly higher than the national induction rate of 32.6% for 2017-18 (NHS Maternity Statistics, NHS Digital, 2017-18).

Rates of induction were reported monthly as part of the maternity dashboard. There was an action plan for induction of labour, as part of the Maternity Transformation Programme Action Plan, to monitor progress with induction rates and experience. This included considering the development of a dedicated induction of labour bay on the maternity ward to reduce variation in care and experience received; reviewing patient experience regarding the induction of labour pathway; and reviewing the induction of labour guidance in line with Saving Babies' Lives recommendations. Service leads could explain these actions to us when we spoke with them at the time of inspection.

Learning from complaints and concerns

The service investigated complaints, learned lessons from the results, and shared these with all staff. There was evidence of using feedback to improve the service.

There was evidence of learning from complaints and feedback. For example, there had been some concerns raised about missed postnatal visits in the community towards the end of 2018, which we have discussed in more detail under ‘access and flow’. To address this, the service had increased their administrative and clerical support to ensure all community visits were booked and took place at the appropriate time.

Staff confirmed they received feedback and learning from complaints through emails and ward daily huddles.

From December 2017 to November 2018 the trust received 19 complaints in relation to maternity (4.4% of total complaints received by the trust). The main subject of complaints was clinical treatment (nine).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>9</td>
</tr>
<tr>
<td>Patient Care</td>
<td>5</td>
</tr>
</tbody>
</table>
For the 14 complaints that had been closed at the time of data submission, the trust took an average of 50.3 working days to investigate and close these. This was not in line with their complaints policy, which states complaints should be closed within 45 working days.

The five complaints that had not yet been closed had been open for an average of 23.0 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From November 2017 to October 2018 there were 334 compliments received for maternity (2.5% of all received trust wide).

Compliments were received in all 12 months of the period. September 2018 was the month where the most compliments were received (40).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run a service providing high quality, sustainable care. Leaders were experienced and had the capability to make sure that a quality service was delivered and risks to performance were addressed.

There was strong local leadership within maternity and appropriate access to the senior leadership team for escalation when required. The service was consultant led but there was also a chief midwife to have oversight of midwifery activity. Staff were aware of who they reported to and could access support from service leads when they needed to.

Local leads were dynamic and invested in quality improvement and staff welfare. Staff consistently reported that local leads were highly visible and supportive. The service had a ‘manager of the day’ system to ensure staff always had someone to contact for support or advice even at busy times. The name of this person was displayed on the information board in each area we inspected, and staff knew who they were and told us this was helpful in managing their workload and accessing support. The manager of the day did a daily walk round of all areas.

The head of midwifery had access to the board and strong working links with the chief nurse and medical director for the trust. The chief nurse had attended the divisional board meeting and chaired the safety sub-board meeting which the service reported into.

There had been significant changes in leadership within the community midwifery team since the beginning of 2019 and four community midwives said this had improved the strength of leadership and the culture within the community team.

There was a group of professional midwifery advocates (PMAs), whose role it was to support midwives through a process of restorative clinical supervision, personal action for quality improvement and preparedness for professional revalidation. Midwives knew about the PMAs and could raise concerns to them in a confidential manner. PMAs met monthly with the head of midwifery to discuss and try to manage these concerns. This was the process through which the community cultural issues were highlighted and acted upon.

Local leads told us that the executive team did monthly walk rounds of the service and felt they were visible and approachable. They felt proud of the communication they had with the executive team and felt the executive team listened to them. However, two junior members of staff on the labour ward said they had not seen the executive team on the wards and did not know the name of the head of midwifery.

Vision and strategy

The service had a vision and strategy and workable plans to achieve this. Staff were involved in the vision and strategy.

There was a trust wide nursing, midwifery and care strategy developed in November 2018 which maternity services fed into. This included 10 commitments such as ‘we will increase the visibility of nursing and midwifery leadership and input in prevention’ and ‘we will work with individuals, families and communities to equip them to make informed choices and manage their own health’.

The service had produced a document to outline some of the measures specific to maternity that were taking place to achieve their strategy. For example, their Maternity Alcohol Management Algorithm (MAMA) pathway, which included a five-step screening test to identify drinking in
pregnancy and had won an innovation award. This was an aspect of promoting their culture to improve population health.

Local leads could explain their areas of focus for the next 12 months and steps for achieving these. The focus for the service over the next year was introducing and embedding the midwifery-led unit which was due to be in place in summer 2019. The service was also continuing their focus on the ‘Saving Babies’ Lives’ programme.

Staff on the ward and in obstetric theatres were aware of and engaged in the service’s vision and strategy.

**Culture**

**Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that they felt proud to work for the service and felt respected and valued.**

There was a positive, team-based and supportive culture. Staff, both medical and midwifery, reported there was a good culture and that they were proud of working in the service. This was reflected in our observations in all areas of the service. There was a supportive culture for new and junior staff; for example, a junior doctor felt well supported and two student midwives said they would like to continue working in the service once they were qualified.

The four community midwives we spoke with said there had been some issues with culture in the last year as they had not felt supported but following changes in leadership and increased oversight and inclusion of the community team, they had noticed improvement.

There was evidence of a learning culture and a willingness of all staff to engage in review of and learning from incidents to improve the service. For example, there was a twice-weekly multidisciplinary review meeting to discuss all incidents graded moderate or above. This was led by the head of midwifery and the governance lead for obstetrics, with input from a consultant paediatrician if required.

The lead consultant for the service told us that the service’s last deanery review in May 2018 had highlighted some concerns for junior doctors in the service. We reviewed the deanery review which highlighted some concerns from junior doctors that not all life support training certificates were checked; that some consultants were difficult to access; and around rota changes. This was for junior doctors across obstetrics and gynaecology, so we could not break this down to apply specifically to doctors in the maternity service.

The lead consultant was able to explain actions they had taken including increased engagement with junior doctors through the junior doctors’ forum. Junior doctors we spoke with during our inspection were positive about the culture at the service and we saw good working relationships.

**Governance**

**There were systems and processes to monitor safety and quality and a clear governance structure.**

There was a clear local governance structure and effective ‘ward to board’ communication and vice versa. The maternity service was part of the surgical, women’s and children’s division. Within this there was a specific maternity directorate which had their own monthly governance meeting.
We reviewed maternity monthly governance meeting minutes from December 2018 to February 2019 and saw good representation from consultants and midwifery representation from wards and theatres. There was a comprehensive standard agenda which included (but was not limited to) learning from incidents; learning from complaints; audit results; infection prevention updates; and updates from the maternity safety initiatives such as performance against the Saving Babies Lives’ care bundle.

We reviewed divisional governance meeting minutes and saw that the issues discussed at maternity directorate level were escalated appropriately. The head of midwifery took part in the divisional governance meetings and would escalate further to the trust board as required. Consultant presence was strong at divisional governance meetings and the meeting could only take place if they were quorate with consultant presence, which meant 50% of consultants from the department.

The service had a comprehensive governance plan documented for improving safety across maternity services since our previous inspection in May 2017. This identified clear steps for improvement and how they were achieving improvement in safety, including (but not limited to) introducing maternity safety champions, introducing the ‘manager of the day’ to manage midwifery staffing red flags in real time; and external engagement with the Maternal and Neonatal Safety Collaborative and with the Maternity Voice Partnership.

This was displayed on information boards in the unit and staff were aware of the safety improvement programme. This was evidence of governance being a responsibility of the whole team. This improvement plan was an integral part of the service and was being monitored regularly through governance meetings to track progress.

Any instance of non-compliance with or deviation from national standards including from the National Institute of Health and Care Excellence, for example due to staffing or capacity issues, was recorded and discussed at governance meetings at divisional and board level.

The service was meeting all ten safety criteria under the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to support the delivery of safer maternity care. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. There was board level scrutiny of performance against each of the criteria.

**Management of risk, issues and performance**

Risks were identified and well managed and matched the risks we saw on inspection and what staff and service leads told us. There was clear oversight of risks and issues with defined members of staff having responsibility.

The service had individual risk registers for the delivery suite, maternity ward, antenatal clinics, community service and screening services. Risks were clearly documented with named leads to manage and review the risks and steps to achieve mitigation of the risks.

The risks were reviewed monthly at local governance meetings and escalated further to board level if required. Local leads were aware of their main risks and could explain the actions they were taking to mitigate them. We saw evidence of this in the governance meeting minutes we reviewed from December 2018 to February 2019. For example, medical staffing had previously been a high risk on their register, but they had successfully recruited to medical vacancies to mitigate the risk.
Service leads and staff consistently reported that midwifery staffing was their main risk and we saw there was an effective recruitment and retention plan to address this risk and remain sustainable. We have provided details under the ‘Safe’ domain.

The service had a joint escalation plan with other trusts in the Greater Manchester area including the regional ambulance service to help ensure the needs of women could be met at times of increased pressure and low staffing or capacity. This procedure and policy also included provisions for severe weather conditions, as the trust was the second highest from sea level in the country so there were some periods when it may not be safe to discharge women and babies.

There were systems to manage risk for community midwives who would be going into women’s homes. There was a lone working policy which was up to date and staff worked in accordance with it, including two midwives being allocated to visit women who were highlighted at risk of domestic violence.

New members of staff recruited to managerial posts received one to one training on managing incidents, risk and governance processes as part of their induction, from the clinical quality lead midwife.

The service had a robust system in place to report qualifying incidents under the NHS Resolutions Early Notification scheme. The scheme requires trusts to report all maternity incidents that have led to severe brain injury and this was managed by the trust legal department.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems and appropriate storage arrangements for paper records.

Staff of all types reported adequate access to information and we saw that handovers included reminders about appropriate information sharing, protection and storage arrangements.

The quality and sustainability of the service received sufficient coverage in relevant meetings at all levels including directorate, divisional and trust board. There were clear and robust service performance measures, which were reported and monitored, and which staff were aware of.

At our previous inspection, access to and management of information among the community midwifery team had been identified as a concern. This was because the community midwives worked remotely and there was no expectation for them to attend the hospital community office regularly. This meant they were relying on phone calls to exchange information.

We saw there was improvement at this inspection, because community midwives were attending the hospital community office much more frequently. There was a plan to roll out the use of laptops for community midwives from April 2019. This would allow access to patient information from patient’s GPs or from the hospital and to complete observations in real time.

The four community midwives we spoke with reported they did not have problems with accessing the information they needed and communicating any information they obtained to the trust acute team and felt the introduction of laptops would further help.

When a patient contacted the maternity triage midwife a record of the call and advice given was kept. This information was available for other midwives.
The service had systems and processes for timely information sharing with external stakeholders including the local clinical commissioning group and national audit programmes.

The service had not had any incidents of data breaches from October 2018 to March 2019.

**Engagement**

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

There were initiatives and forums to promote staff engagement in the service. For example, as part of the service’s focus on developing their midwifery-led continuity model of care, the head of midwifery had engaged a group of midwives in a pilot to assess how this would work, with midwives having their own full caseload of women. The head of midwifery was holding weekly meetings with women in this pilot group to obtain their feedback.

The head of midwifery had recently introduced a monthly newsletter to engage with staff and share information. This included updates on projects and workstreams, learning from incidents, and individual staff achievements or special mentions.

Local leads reported staff were engaged in the service and this helped their retention rates and helped to encourage student midwives to apply to work at the service once qualified. This was reflected by midwives we spoke with.

There was a junior doctors’ forum where junior doctors could discuss issues or concerns or make suggestions to improve the service and it could also act as a means of debrief. This was attended by the education lead to help identify any areas where junior doctors required additional support. We were told the service was focusing on ensuring medical university placements and provided a positive and educational opportunity to encourage students to later apply for roles in the service.

There were opportunities for midwives to take part in regional forums for learning and development opportunities. For example, five midwives could request to take part in the north-west regional midwifery conference.

The maternity ward had won a trust ‘best dressed ward’ award in 2018 which had encouraged staff to come up with ideas about how to display the ward and the designs of the display boards in the ward.

The service had recently introduced a service user forum to increase their engagement with women and families who used the service and use their feedback to develop the service. There was a service user lead representative as part of this who was going to meet with local leads quarterly to obtain their feedback.

**Learning, continuous improvement and innovation**

The service had several examples of innovation, sustainability and improvement and engaged all staff members in the process of quality improvement. For example, the community team was working to streamline the clinics they offered, as there were 17 which meant community midwives spent a lot of time travelling between clinics. They were working with the local council to implement midwifery support hubs in leisure centres or other council premises, which would help with accessibility for both staff and women.

Service leads were proud of the initiatives they had implemented to maintain and improve patient care, which were tailored to the local population, such as their Maternal Alcohol Management Algorithm (MAMA) pathway for assessing and responding to alcohol consumption in pregnancy.
The service was active in regional maternity forums to share good practice and encourage learning and had links with universities to learn from new research and how they could use it to improve the service. For example, they were liaising with a midwifery forum elsewhere in the country to review and implement a post-partum haemorrhage pathway with an early warning scoring system to help prevent deterioration and identify risk as early as possible.

The service was in the process of developing a mobile phone app which would allow women to access their own maternity care records.
Community health services

Community health services for adults

Facts and data about this service

Tameside and Glossop Integrated Care NHS Foundation Trust provide a wide range of community based health and specialist nursing and community therapy services. Care is provided in patients homes, clinics and healthcare centres to adults aged 18 and above across Tameside and Glossop area.

Community adult services was part of the Tameside and Glossop integrated model that are commissioned by Tameside CCG.

The integrated model in the community served five neighbourhood teams; Hyde, Glossop, Ashton, Denton, Audenshaw and Droylsden and Dukinfield, Stalybridge and Mossley.

The integrated multidisciplinary team provides holistic home-based care and support, to enable care provision in the most appropriate environment and provide a combination of visits relating to both planned and unplanned care needs, both in core hours and during the ‘out of hours’ period with the district nursing service covering the full 24-hour period.

District nursing teams are co-located with social work and therapy staff who work closely with other services including digital health; integrated urgent care team (IUCT); extensive care team; intravenous therapies; podiatry; falls, diabetes; heart failure; continence; physiotherapy; nutrition and dietetics; speech and language; community neurological rehabilitation; chronic obstructive pulmonary disease (COPD) and the asylum seekers service.

Information about the sites and teams, which offer community services for adults at Tameside and Glossop Integrated Care NHS Foundation Trust, is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Team name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Street Health Centre</td>
<td>Community podiatry service</td>
<td>Ann Street, Denton, Manchester, M34 2AJ</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal podiatry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult community physiotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pulmonary rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal physiotherapy</td>
<td>193 Old Street, Ashton-under-Lyne, OL6 7SR</td>
</tr>
<tr>
<td></td>
<td>Community podiatry service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ashton district nursing service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continence service</td>
<td></td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Integrated diabetes service</td>
<td>193 Old Street, Ashton-under-Lyne, OL6 7SR</td>
</tr>
<tr>
<td>Centre/Dewsnap Lane Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crickets Lane Health Centre</td>
<td>Asylum seekers service</td>
<td>Crickets Lane, Ashton-under-Lyne, OL6 6NG</td>
</tr>
<tr>
<td></td>
<td>Extensive care team</td>
<td></td>
</tr>
<tr>
<td>Site name</td>
<td>Team name</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>Integrated Urgent Care Team (IUCT)</strong></td>
<td>community setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out of hours district nursing service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>District nursing single point of access (SPOC) service</td>
<td></td>
</tr>
<tr>
<td>Denton Festival Hall</td>
<td>Denton district nursing service</td>
<td>13 Peel Street, Denton, Manchester, M34 3JY</td>
</tr>
<tr>
<td>Dewsnap Lane Clinic</td>
<td>Community podiatry service</td>
<td>Dewsnap Lane, Dukinfield, SK16 5AW</td>
</tr>
<tr>
<td></td>
<td>Tissue viability service</td>
<td></td>
</tr>
<tr>
<td>Dukinfield Town Hall</td>
<td>District nursing night service</td>
<td>King Street, Dukinfield, SK16 4LA</td>
</tr>
<tr>
<td>Glossop Primary Care Centre</td>
<td>Musculoskeletal physiotherapy</td>
<td>George Street, Glossop, SK13 8AY</td>
</tr>
<tr>
<td></td>
<td>Community podiatry service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glossop district nursing service</td>
<td></td>
</tr>
<tr>
<td>Hattersley Clinic</td>
<td>Community podiatry service</td>
<td>Hattersley Road East, Hyde SK14 3EH</td>
</tr>
<tr>
<td>Mosley Health Centre</td>
<td>Community podiatry service</td>
<td>Market Place, Mossley, Ashton-under-Lyne, OL5 0HE</td>
</tr>
<tr>
<td>Selbourne House</td>
<td>Community dieticians</td>
<td>Union Street, Hyde, SK14 1NG</td>
</tr>
<tr>
<td></td>
<td>Community neuro rehab</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hyde &amp; Hattersley district nursing services</td>
<td></td>
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<tr>
<td>Stalybridge Civic Hall</td>
<td>Stalybridge district nursing service</td>
<td>Trinity Street, Stalybridge, SK15 2BN</td>
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<tr>
<td>Tameside General Hospital</td>
<td>Adult speech and language team</td>
<td>Fountain Street, Ashton-under-Lyne, OL6 9RW</td>
</tr>
<tr>
<td></td>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 43 Ladysmith</td>
<td></td>
</tr>
<tr>
<td>Union Street Clinic</td>
<td>Community podiatry service</td>
<td>46 Union Street, Hyde, SK14 1NX</td>
</tr>
<tr>
<td></td>
<td>Community IV therapy team</td>
<td></td>
</tr>
</tbody>
</table>
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training was accessed either by e-learning or within the classroom setting. Staff told us class room training was offered across various locations within the community to promote accessibility to all community service staff.

The trust set a target of 95% for completion of mandatory training and we observed the majority of staff across community adults services had completed their mandatory training.

In addition to the data below, the trust provided overall compliance data for resuscitation and PREVENT training for all relevant staff across community adult services as of 31 March 2019. This showed

- Basic life support - 86% compliance
- Intermediate life support - 100% compliance
- PREVENT level 1 and 2 - 100% compliance
- PREVENT level 3 - 100% compliance.

Qualified nursing staff

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling level 1</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
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<tr>
<td>Equality and diversity</td>
<td>114</td>
<td>116</td>
<td>98.3%</td>
<td>95%</td>
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</tr>
<tr>
<td>Health and safety</td>
<td>113</td>
<td>116</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>112</td>
<td>116</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>109</td>
<td>116</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>105</td>
<td>112</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>108</td>
<td>116</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for adults the trust had an overall mandatory training compliance rate of 95.5% for qualified nursing staff. The 95% target was met for four of the seven mandatory training modules for which qualified nursing staff were eligible.
Medical staff

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for medical staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
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<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community services for adults the trust had an overall mandatory training compliance rate of 100.0% for medical staff. It should be noted this only relates to two eligible staff, so performance should be considered in this context.

Qualified allied health professional staff

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified allied health professional staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
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<tr>
<td>Equality and diversity</td>
<td>128</td>
<td>128</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>128</td>
<td>128</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>127</td>
<td>128</td>
<td>99.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>127</td>
<td>128</td>
<td>99.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>124</td>
<td>127</td>
<td>97.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>123</td>
<td>128</td>
<td>96.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community services for adults the trust had an overall mandatory training compliance rate of 98.7% for qualified allied health professional staff. The 95% target was met for all seven mandatory training modules for which qualified allied health professional staff were eligible.

Safeguarding

Data provided showed all staff across community adult services had met the trust target of 95% for safeguarding training. Staff we spoke to understood how to protect patients from abuse and the service worked well with other agencies to do so.

Qualified nursing staff
A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for qualified nursing staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
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<td>95%</td>
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<tr>
<td>Safeguarding adults</td>
<td>113</td>
<td>116</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>109</td>
<td>114</td>
<td>95.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community services for adults the trust had an overall safeguarding training compliance rate of 96.6% for qualified nursing staff. The 95% target was met for all three safeguarding training modules for which qualified nursing staff were eligible.

Data provided showed between December 2017 and November 2018 there were 34 safeguarding referrals made from community adult services.

**Medical staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for medical staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community services for adults the trust had an overall safeguarding training compliance rate of 100.0% for medical staff. It should be noted this only relates to two eligible staff, so performance should be considered in this context.

**Qualified allied health professional staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for qualified allied health professional staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>128</td>
<td>128</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In community services for adults the trust had an overall safeguarding training compliance rate of 99.6% for qualified allied health professional staff. The 95% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

The trust had implemented a safeguarding adult managers (SAM) model that focussed on developing specialist named professionals and advisors to safeguard adults at risk of harm and abuse. In addition, the role empowered practitioners to raise awareness of training and policies to staff across the service.

Safeguarding adult managers were supported by named nurses. During our inspection, staff were aware of who the safeguarding adult managers were in their teams. Data provided showed there were 35 Safeguarding Adult Managers (SAM) across community adult services, with 16 of those based within the district nursing teams.

Staff who had completed level 3 safeguarding training also received domestic abuse training as part of their “Essential Training”.

Staff had access to support, advice and guidance around processes for domestic abuse from a trust lead from Monday to Friday, in addition to the trust safeguarding team. Data provided showed there were 25 domestic abuse champions across the trust. However, we did not receive clarification of the number of champions within community adult services.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Safeguarding referrals - adults

The trust made 34 safeguarding referrals concerning adults within community services for adults from December 2017 to November 2018.

Looking at adult referrals across the 12 month period, overall there was a stable trend in referrals with peaks in August 2018 (8) and February 2018 (6).

Safeguarding referrals - children

The trust did not provide a breakdown by core service for safeguarding referrals made...
concerning children. From December 2017 to November 2018, the trust made 3,754 safeguarding referrals concerning children trust wide to the Trust Safeguarding Children Team.

Looking at child referrals across the 12 month period, overall there was a stable trend in referrals with peaks in January 2018 (381) and October 2018 (390).

Cleanliness, infection control and hygiene
The service controlled infection risk well. Staff had access to infection control policies including ‘bare below the elbow’ and ‘hand hygiene’ policy.

There were infection prevention champions based across community services and we observed minutes from team leaders meeting that stated they met monthly. During our inspection we observed staff consistently followed ‘bare arms below the elbow’ guidance and used appropriate hand hygiene techniques.

All the equipment we observed and the areas we visited were visibly clean and tidy. Personal protective equipment (PPE), such as aprons and gloves, were readily available and in use in all areas.

Staff carried hand gel to use if they did not have access to hot water and soap to wash their hands before and after care.

Environment and equipment
The service had suitable premises and equipment and looked after them well.

We observed environments were visibly clean and tidy with appropriate labelling, storage and disposal of clinical and non-clinical waste. Some of the community adult services we visited were provided in clinical rooms used by multiple users.

We checked samples of consumables in the locations we visited. All but one was found to be in date and this was escalated and removed from use at the time of inspection.

The services had access to equipment to provide care and treatment. All equipment we checked during our inspection was found had been serviced. Data provided by the trust showed that 76% of equipment had been serviced within the recommended date. However, we were told that although they were confirming the accuracy of the figure, the trust were taking actions to ensure that the percentage of equipment in date for maintenance was optimised.

There were no facilities within the clinics to offer leg washes to leg ulcer patients in between weekly compression bandage changes. One member of staff told us this had been raised and new equipment including washing bowls on wheels were being sought. During our inspection a patient confirmed their leg had never been washed. However, the patient was provided with a cover to keep the bandage dry to enable them to shower at home.

Equipment such as mobility aids and commodes were stored at Crickets Lane health centre and were accessible to staff seven days a week. Staff across community services had a personal identification number to request specialist equipment such as mattresses from an external provider who delivered these to patient’s homes. Staff told us emergency equipment was delivered within four hours.

Assessing and responding to patient risk
There were systems and processes in place to manage patient risk. Risk assessments were completed in people’s homes to keep staff and patients safe. Patient assessments included malnutrition universal screening tool (MUST) scores which were assessments of nutrition and hydration, mobility, Waterlow scores for the risk of pressure ulcer development and falls assessments.

Staff told us falls risk assessments were if required, completed by the therapy team who they would contact if there were any concerns. During our inspection we reviewed eight patient records. We found risk assessments had been completed on admission. However, we found these were not consistently reviewed and updated for two patients.

We observed in one record that a patient should have received a frailty screen as they were over 75 years of age. However, this had not been completed. We raised this to the team lead at the time of inspection.

Staff told us an environmental risk assessment was completed, if a risk had been identified and any risk would be documented on the electronic record and shared at safety huddles. However, we did not see any environmental risk assessments completed in the records we reviewed. The leg ulcer service, extensive care team and the integrated urgent care team performed holistic assessments and we were told they would complete specific risk assessments if indicated. We reviewed three records and observed and noted a full holistic assessment had been performed that included mobility issues, falls and nutritional status.

There was a community sepsis screening bundle for adults for staff to follow in identifying a patient who could have sepsis. The pathway included observations to be undertaken including temperature and oxygen saturations. However, not all staff were provided with equipment to monitor a patient’s oxygen saturation or to take a tympanic temperature, as per guidance. One team leader told us oxygen saturation monitors had been discussed the previous day and it was decided that there were other ways to review a patient. However, there was a plan that all band five nurses were to receive equipment to take tympanic temperature.

The trust told us staff had received training in the sepsis bundle during trust induction along with ad hoc training sessions. However, the trust could not provide actual numbers of staff trained across community adult services.

Staff told us they would use their clinical judgement if a patient was poorly and gave examples of what they had done including call the GP or the emergency services.

Each district nursing team held daily safety huddles to discuss and review patients, raise concerns or issues. However, we visited one team that had safety huddles three times a week due the large area and distance staff covered, but we were told staff were still required to come into the office at least once a day. During our inspection we attended a safety huddle and observed effective collaborative working, prioritisation, delegation and open conversations.

Staff told us patients with complex needs were given a specific mobile number so they could directly contact the nurse if they required urgent advice or assistance.

Staff liaised with the out of hours and overnight team about any patients who would potentially contact and request a visit. During our inspection we observed a list of patients with specific actions to take if they were to contact the out of hours team. The team leader for the out of hours service told us they would email information to the patient’s district nursing team if they were called out and also add this to the electronic patients record.
Staffing

Staffing levels across community nursing services were adequate although there was great reliance on bank staff.

Although the district nursing services did not use an acuity and weighting tool to allocate work, team leaders were confident that each member of the team had an appropriate workload. We observed that this was discussed and reviewed in the morning and at lunch time. If required, workload was re-distributed across the team, to the evening service or deferred to the following day. We were told the service was currently developing a complexity and dependency tool to assist in the triangulation of data to ensure safe and effective caseloads.

The service had a deferral process in place and although this was not ratified at the time of inspection, all staff were aware of the process and we observed this during our inspection. Decisions were based on patient risk and need and were made by senior nurses. Each district nursing team submitted information daily to senior managers who responded to any issues regarding the safety of patients or timely care. The trust confirmed there were no occasions where a deferred visit had resulted in any patient safety issues.

Following our inspection, the trust provided a copy of a recently ratified policy; ‘admission, care management and discharge that included caseload management, roles and responsibilities and allocation of workload including deferral.

We reviewed staff rotas and observed there were occasions when there was great reliance on bank staff to cover for both vacancies and sickness. Team leaders told us the same bank staff were utilised and although staffing levels were not always met, they said there was no impact on patient safety.

Staff we spoke to told us confirmed that although they were busy, there was no impact on patient care or safety. However, staff from the leg ulcer team felt that they did not have enough staff and this resulted in tasks not being completed such as photographing wounds. We were told these were not always reported as incidents as they did not have time to return to the office to report them.

Patients were given a named nurse to promote continuity of care and during our inspection staff confirmed they tried to visit the same patients.

The director for intermediate tier services told us they were currently developing dashboards for each speciality that would give an overview of capacity and demand including quiet and busy periods.

Qualified nursing staff

The trust reported the following qualified nursing staff numbers for the two periods below for community services for adults:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Qualified nursing staff  |  122.3  |  133.1  |  91.8%  |  113.6  |  125.4  |  90.6%

The trust reported a qualified nursing staffing level of 91.8% in community services for adults from April 2017 to March 2018. This decreased to 90.6% from April to November 2018.

From April to November 2018, there were 11.8 fewer WTE staff in post than planned for and 10.8 fewer WTE staff in post than from April 2017 to March 2018. There was a decrease of 7.7 WTE planned posts between the two time periods.

**Medical staff**

The trust reported the following medical staff numbers for the two periods below for community services for adults:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Medical staff</td>
<td>1.4</td>
<td>2.0</td>
</tr>
</tbody>
</table>

The trust reported a medical staffing level of 67.5% in community services for adults from April 2017 to March 2018. This decreased to 53.8% from April to November 2018.

From April to November 2018, there were 0.3 less WTE staff in post than from April 2017 to March 2018. The number of planned WTE posts (two) remained the same between the two time periods. There were two general practitioners employed part time as part of the extensive care team who provided medical supervision.

**Qualified allied health professional staff**

The trust reported the following qualified allied health professional staff numbers for the two periods below for community services for adults:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>96.3</td>
<td>103.3</td>
</tr>
</tbody>
</table>

The trust reported a qualified allied health professional staffing level of 93.2% in community services for adults from April 2017 to March 2018. This increased to 96.6% from April to November 2018.

From April to November 2018, there were 3.3 less WTE staff in post than planned for and 7.0 less WTE staff in post than from April 2017 to March 2018. There was a decrease of 5.2 WTE planned posts between the two time periods.

**Vacancies**
The trust set a 4% vacancy rate target. From December 2017 to November 2018, the trust reported an overall vacancy rate of 5.3% in community health services for adults. This did not meet the trust’s target. Across the trust overall vacancy rates for nursing staff were 11.6%; for medical staff were 33.7% and for allied health professionals were 5.2%.

A breakdown of vacancy rates by staff group in community health services for adults at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>-204.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>-47.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>2.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>2.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>31.3%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>32.5%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>58.3%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>5.3%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The negative vacancy rate for support to doctors and nursing staff represents an over-establishment in this staff group. However, this is not the case for other qualified scientific, therapeutic & technical staff and is due to the trust providing negative vacancy figures in the PIR.

**Turnover**

The trust set a target of 12% for turnover rate. From November 2017 to October 2018, the trust reported an overall turnover rate of 13.2% in community health services for adults. This did not meet the trust’s target.

A breakdown of turnover rates by staff group in community health services for adults at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Turnover rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>4.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>11.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>11.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>15.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>18.2</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>99.2%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>13.2%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
It should be noted the medical & dental staff group relates to a very small number of eligible staff so care should be taken when interpreting the turnover rates for these groups.

**Sickness**

The trust set a target of 4.2% for sickness absence. From November 2017 to October 2018, the trust reported an overall sickness rate of 5.4% in community services for adults. This did not meet the trust's target.

A breakdown of sickness rates by staff group in community health services for adults at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Sickness rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>1.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>3.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>5.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>5.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>6.6%</td>
<td>No</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>9.9%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>5.4%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Some of the services we visited old us there were staff who were on long term sick, although we were told this was improving with the majority of staff recently returned or due to return. Team leaders reported it did have an impact on staffing as bank staff were utilised. However, this was difficult for specialised services such as the tissue viability team as they could not get suitably qualified bank staff to provide cover.

**Nursing – Bank and Agency Qualified nurses**

From December 2017 to November 2018 the trust reported 3,526.0 of the 162,220.5 available hours were filled by bank staff (2.2%) and 204.6 were filled by agency staff (0.1%) for qualified nursing staff in community services for adults. There were 5,931.5 hours that needed to be covered by bank or agency staff but were left unfilled (3.7%).

The trust gave the reason of 'vacancies' for the usage of bank and agency staff.

A breakdown of bank and agency usage is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>3,526.0</td>
</tr>
</tbody>
</table>
Nursing - Bank and Agency Non-Qualified nurses

From December 2017 to November 2018 the trust reported 1,826.0 of the 54,405.0 available hours were filled by bank staff (3.4%) and none were filled by agency staff for non-qualified nursing staff in community services for adults. There were 2,071.0 hours that needed to be covered by bank or agency staff but were left unfilled (3.8%).

The trust gave the reason of 'vacancies' for the usage of bank and agency staff.

A breakdown of bank and agency usage is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>December 2017 to November 2018</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank Hours</td>
<td>Bank %</td>
<td>Agency Hours</td>
<td>Agency %</td>
<td>Unfilled Hours</td>
</tr>
<tr>
<td>Non-qualified nursing staff</td>
<td>1,826.0</td>
<td>3.4%</td>
<td>0.0</td>
<td>0.0%</td>
<td>2,071.0</td>
</tr>
</tbody>
</table>

Medical locums

The trust did not report any medical locum usage in community services for adults from November 2017 October 2018.

Suspensions and supervisions

During the reporting period from December 2017 to November 2018, community services for adults reported that there was one case where staff had been suspended. During the same period, there were no cases where staff had been placed under supervision.

Quality of records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to staff providing care.

Patient care was predominantly recorded on paper records that were left within the home setting and information was accessible to other visiting services. Duplicates of information were stored securely within the staff office. All teams were also using a dedicated electronic record system that was being rolled out across the trust. Some clinic services, for example high risk podiatry and diabetes services, were solely documenting all patient information within the electronic record. The system meant patient information, including specific service provision and treatment at point of care, was accessible across all community services, although this was currently only accessible in the staff locations. The majority of nursing staff told us they checked the electronic system prior to a home visit to identify if any other services were also visiting the patient.

Staff told us the plan was to become' paper light.’ Once specific service templates had been devised on the electronic system, for example care plans, staff would be provided with an electronic device to use within patient homes.

We looked at eleven care records and saw that entries were legible and mostly complete apart from some areas with information missing for example, patient’s baseline observations, completion
of body maps and NHS numbers on every page. The patient records recorded a clear plan of care for all, but one patient and we observed completed wound assessments that were easy to follow with regards to wound status and current treatment.

The integrated urgent care community team had access to patient information on the local authority record for Tameside patients. The service did not have direct access to Glossop local authority patient record’s, but they told us they could contact an identified person for information. Staff told us this assisted in triaging and identifying any risks of the patient or their environment. Patients receiving care from the team each had a paper record in their home that, following discharge, was scanned onto the local authority system for information. We reviewed a patient’s record and observed the patient’s needs were identified through assessment and discussion. All pages were completed with the patient’s name, date of birth along with date of visit and time of arrival and departure. However, information regarding any allergies was not filled in.

The extensive care team documented care on the electronic system and had access to additional information including medications, blood results and GP consultation for most of the GP surgeries. Staff told us they would contact or visit the GP surgery and obtain required information from those services they did not have electronic access to. The service did not complete paper records within the patient’s home, but we were told they would leave contact numbers. We reviewed one electronic patient record from the extensive care service and found there was a clear documented assessment and plan of care for the patient at each visit.

In November 2018 an audit of ten randomly selected sets of paper records was performed across community adults services. The audit included all entries relating to the service, up to a maximum of the last five contacts with the patient. The audit reported entries were overall generally legible with 97% recorded in consecutive order. Areas for improvement included compliance with recording of a printed name (78%), designation (76%), alterations countersigned (68%), dated (18%) and timed (9%).

The records audit did not include review of whether staff had followed guidance in relation to assessing patient risk for example completion of risk assessments.

We observed action plans had been devised to address areas requiring improvement including feedback to teams and amending signature sheets to incorporate professional registration numbers. Staff we spoke to were aware of the audit and actions taken.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients we reviewed had received the right medication at the right dose at the right time.

Between August 2018 to February 2019, there were 27 incidents reported across community adults services relating to medication, of those eight resulted in low harm and 19 in no harm. The majority were reported as administration issues.

During our inspection, staff shared incidents relating to medicines including reactions to an intravenous antibiotic that was escalated to the Medicines and Healthcare products Regulatory Agency via the yellow card scheme. These had been reported as incidents and action was taken including changes to the pathway and inform patients of the risk.

Prescription sheets for community staff to administer medications to patients were left in the patient’s homes or within clinic records. During our inspection, we reviewed three prescription records and found these to be legible and fully completed.
Across community adult services there were non-medical prescribers; this allowed patients to receive medications and prescription only dressings in a timely manner. Staff told us prescription pads were stored in a locked draw or cupboard when not in use and we observed this during our inspection.

Patient’s intravenous medications were kept within their own homes and patients were provided with a fridge thermometer for those requiring refrigeration. The community intravenous therapy service had access to a stock of intravenous fluids at their clinic to utilise if required and we observed these were stored in a locked cupboard at the location.

All referrals to the community intravenous (IV) therapy team were checked and a virtual clinic was held with a microbiologist based at the hospital. Antibiotic risk assessments were completed prior to administration. Staff told us the chief pharmacist, along with every staff member, had a copy of the patient group directives including for anaphylaxis.

All registered nurses were provided with adrenaline and equipment to administer secured within a box. Staff told us each team had a batch issued at the same time and a log was made to note the expiry date of the adrenaline. During our inspection, we observed at one location a log that included the adrenaline issued to each member of staff and the expiry date. Adrenaline we checked at the time of inspection was found to be in date.

The trust had a neighbourhood pharmacy team consisting of ten whole time equivalent pharmacists who worked across both the primary and secondary care setting. The teams role was to optimise medications by reducing polypharmacy and reducing hospital admissions and outpatient attendances. The team focused on helping and supporting vulnerable patients with their medication or at risk of hospitalisation by supporting with medication queries and improving communications between health services including General Practice, community pharmacy, hospital pharmacy on admission, discharge and social services.

Safety performance

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.

Community Settings

Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, 14 falls with harm and three new catheter urinary tract infections from January 2018 to January 2019 within community settings.

All grade two pressure ulcers and above were reported on the incident reporting system and these were investigated by the district nursing team leader and reviewed at the pressure ulcer scrutiny group. We reviewed two sets of minutes and observed these were attended by the head of nursing
and community team leaders who reviewed investigations into incidents relating to pressure ulcers were reviewed with outcome and learning documented.

During our inspection we observed details displayed regarding how many days since the team had reported a pressure ulcer.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Tameside and Glossop Integrated Care NHS Foundation Trust – Community settings.

**Total Pressure ulcers (16)**

**Total Falls (14)**

**Total CUTIs (3)**

**Incident reporting, learning and improvement**

The service managed patient safety incidents well and assisted in learning and improving care. Staff recognised incidents and reported them appropriately.

The trust used an electronic system for reporting incidents, concerns or near misses.
Staff felt there was a positive reporting culture and knew what incidents to report. Staff gave examples of incidents they had reported along with changes in practice and told us they usually received feedback.

Managers monitored themes and trends with the top three, from August 2018 to February 2019, reported as pressure ulcers, staffing (deferred visits) and medication. Data provided showed actions had been taken to address issues including introducing a sub group to the Pressure Ulcer Prevention Committee: Community Pressure Ulcer Scrutiny Group, additional training and changes in process.

We saw that incidents and lessons learned were discussed at team and quality and safety meetings and shared on the “Learning in Practice template” and displayed on teams ‘How are we doing?’ boards.

In November 2019, the patient safety team delivered Duty of Candour ‘toolbox talks’ to staff in the community that also reinforced key messages and gave staff the opportunity to raise queries regarding the incident reporting process. We were told the team planned to deliver additional training in relation to the completion of investigations into serious incidents in April 2019.

Serious Incidents

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in community services for adults which met the reporting criteria set by NHS England from December 2017 to November 2018. All of the incidents reported were pressure ulcers.

We reviewed investigations following three serious incidents relating to pressure ulcers and saw lessons were learned and, where required, actions were put in place to reduce the risk of the incident happening again.

Team leaders told us they investigated serious incidents and fed back lessons learned to their teams along with other team leaders.

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.

From December 2017 to November 2018, the trust reported no incidents classified as never events for community services for adults.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports relating to community services for adults.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Policies and guidelines were based on national and local guidelines including National Institute for Health and Care Excellence (NICE). For example, the policy for the prevention and management of pressure ulcers referenced clinical guidance 179 pressure ulcers: prevention and management.

We reviewed a range of policies and pathways and found them to be in date and reflect best practice, for example patient slips, trips and falls policy, prevention and management of pressure ulcers and a pathway for cellulitis.

Staff we spoke to were knowledgeable about the policies and pathways. During our inspection, staff gave us examples of National Institute for Health and Care Excellence guidance they were following, for example, the Parkinson’s disease Quality standard (QS164).

A copy of National Institute for Health and Care Excellence CG176 Pressure ulcers: prevention and management to the appropriate patients was filed in the front of patient’s records. The guidance informed patients of the importance of pressure area care and explained treatment management of pressure ulcers.

During our inspection, some staff told us they kept themselves up to date with guidance by reading journals and staff from the community neurological rehabilitation team attended journal clubs where they would review and discuss recent articles.

Patients had their needs holistically assessed using a number of evidence-based assessment tools. For example, the extensive care team used the patient activation measure (PAM) tool to understand a patient’s ability and confidence to manage their own health and wellbeing.

Senior managers told us staff compliance with following guidance was checked through scrutiny of incidents, audits and complaints.

Staff worked with patients to identify and agree patient centred goals that were achievable. We saw evidence of this in patient records we reviewed.

Nutrition and hydration

Where appropriate, patients were given advice on nutrition and hydration to meet their needs and improve their health.

We saw evidence in patient’s records that patient’s nutrition and hydration needs were discussed and reviewed and those requiring additional support or assessment were referred and reviewed by the community dietitian or the speech and language team.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, provided advice and signposted to other health care professionals, if required.

We saw evidence in patient records we reviewed, that pain was assessed and managed appropriately. We did not see evidence within the records of a specific pain tool used and this was confirmed by a team leader. However, we observed patients were asked to describe their level of pain using a score of 0-10.
Documentation within leg ulcer records included a pain analogue scale for pain at day time, night time and during dressing change. During our inspection we observed staff discussing and assessing pain with patients during their consultation and offering advice where appropriate.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. Outcomes for people who used services were positive and some exceeded expectations.

The trust worked with commissioning bodies under a payment framework called ‘Commissioning for Quality and Innovation’ (CQUIN). This framework enabled commissioners to financially reward providers who achieved agreed quality targets.

We reviewed data submitted as part of a two year CQUIN regarding wounds that had failed to heal within four weeks. Overall compliance for quarter two showed areas of improvement including a 21% increase in the number of patients whose frequency of visits has been reduced and a 20% increase in the number of patients who have shown signs of healing within the last four weeks. Action plans were in place to target areas requiring improvement, for example, improving the referral pathway for tissue viability and high-risk foot team for wound specialist wound assessment.

Patient outcomes were also monitored through key performance indicators (KPI’s), where specific targets were required such as referral to treat times and admission avoidance. Patient outcomes and performance were discussed at risk committees and the programmes leads meeting held monthly.

Data provided at the time of inspection showed patients needs were being met.

Example of data provided included;

**Digital health team**
- working in partnership with the local authority (community response service) responded to 3,189 falls at home during October 2017 and October 2018. This prevented up to 2,799 ambulance call outs.
- Using virtual technology in care homes
  - avoided up to 1981 unnecessary attendances to the accident and emergency department

**Extensive care team**

Data provided for July 2018 to September 2018 showed:
- 58% reduction in emergency department attendance (target 14%)
- 82% reduction in non-elective admissions (target 23%)
- 25% reduction in out-patient attendances (target 4%)

**Community IV service**

Data provided for quarter two (July 2018 to September 2018):
- 279 bed days were saved at the trust
- 336 bed days saved at other trusts

The community neurorehabilitation team told us they monitored patient outcomes using the Barthel score or the modified Rankin scale for stroke patients and received feedback regarding key performance indicators at team meetings.
The Stalybridge neighbourhood team had recently implemented the frailty and falls scheme and data provided showed 243 patients were reviewed by the frailty multidisciplinary team, of those;

- 80 people were referred to the community response service,
- 15 people were referred to the extensive team,
- 48 people were referred to ‘action together’ for social prescribing,
- 21 people were referred to the integrated urgent care team,
- 19 people were supported by the district nursing service,
- 43 people were supported by adult social care,
- 48 people were referred to community physiotherapists.

The trust data showed that they were planning to roll this out across the other neighbourhoods. In response to a high number of diabetic patients at one location, requiring administration or assistance with the administration of insulin, the diabetes specialist nurses reviewed patients to identify if their care provision could be improved, for example, insulin administered three times a day reduced to once daily injections. Managers told us they were also engaging with GP’s to review patients and we observed this in the team leader meeting minutes.

All district nursing teams each had a board identifying patients with diabetes and staff rang in to confirm their insulin had been given. This was to ensure all patients had received a visit, but also confirmed staff were safe if they did not have time to return to the office.

The service participated in national audits as part of their clinical audit programme. These audits assisted reviewing and monitoring of services and their outcomes but also an opportunity to benchmark against other trusts.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Date completed</th>
<th>Key Successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Pulmonary rehabilitation</td>
<td>National Clinical Audit Respiratory Physiotherapy Extensive Care Team</td>
<td>December 2017</td>
<td>Multidisciplinary teams collaborative working</td>
<td>• Project to investigate the use of patient activation measures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Conversion rate from referral to assessment at 100% is in line with National mean 91%</td>
<td>• Review of the standard operating procedures to ensure they cover the recommended elements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Patients are appropriately referred to the team, managed at home and referred on where appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The team are effective in the rehabilitation they provide and the promotion of patient self-management and independence</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 100% patients had confidence and trust</td>
<td></td>
</tr>
<tr>
<td>The National Intermediate Care (IC) Audit</td>
<td>Home based intermediate care and the crisis response service</td>
<td>May to August 2018</td>
<td></td>
<td>• Improve Crisis response time to no greater than two hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve Home based intermediate care response time to less than seven days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Explore options to reduce average duration of time patients have with the service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Promote the “Step up” pathway to home based intermediate care from the community and the emergency department</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Initiatives to enable recruitment and retention of staff</td>
</tr>
</tbody>
</table>
100% felt they were treated with respect and dignity

| The 2017 UK Parkinson’s Audit | The Parkinson's Disease Nurse, Occupational Therapy, Physiotherapy and Speech and Language Therapy | September 2017 | Multidisciplinary approach to working.
| | | | • Patients can access a Parkinson’s Nurse Specialist.
| | | | • Good rate of patients with Parkinson’s Disease reviewed at 6-12 monthly intervals.
| | | | • Staff have access to Parkinson’s related CPD.
| | | | • Parkinson’s-specific induction for those new to working with Parkinson’s.
| | | | • Ensure that all patients receiving physiotherapy have appropriate outcome measures in use to monitor progress during intervention.
| | | | • Improve opportunities for people with Parkinson’s and their carers to discuss end-of-life issues with appropriate healthcare professionals.
| | | | • Increase signposting of patients to Parkinson’s UK.
| | | | • Increase range of evidence-based practise to support staff working with patients with Parkinson’s Disease.
| | | | • Enable delivery of Lee Silverman Voice Treatment (LSVT) to appropriate patients.
| | | | • Improve documentation of advice given about potential side effects of new medication.

The service also participated in local audits including intermediate tier record keeping audit and bisphosphonate patient group direction (PGD) audit.

We reviewed the national and local audits and found recommendations and action plans in place to target areas requiring improvement.

We observed the risk of sub optimal patient experience or outcomes as a result of non-compliance with National Institute for Health and Care Excellence guidance in relation to the management of leg ulcers (doppler scanning) had recently been added to the risk register. Trust data showed there were four registered nurses and one advanced nurse practitioner in the leg ulcer service, who had completed doppler training. At the time of inspection data provided showed:

- 19 (6.8%) patients with leg ulcers who had not received a reassessment within the expected three months
- 30(10.8%) of patients who had healed but had not received a routine annual doppler assessment.

The service was taking action to address the issue and we were informed the expectation was that all outstanding patients would be seen by beginning June 2019.

To increase the numbers of staff across community teams to become competent in leg ulcer assessment, the service had a training plan.
Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff had access to a trust wide clinical support and supervision. Staff across the services told us that clinical supervision took place via a variety of means. This included; informal discussions, formal supervision sessions, one to one meeting with managers, and via team meetings and we saw evidence of this during our inspection. Staff told us they felt supported by their peers, managers and senior managers.

Formal supervision was provided to newly qualified nurses via preceptorship including informal monthly meetings and formal discussions at three, six and 12 months post registration. Allied health professional clinical supervision included all monthly one to one meetings and joint work such as accompanied visits and reflective practice with their clinical supervisor.

The trust offered support and advice to qualified nurses through their revalidation from a designated revalidation lead nurse, a co-ordinator and the HeART programme. We spoke with two nurses who had recently revalidated and they felt fully supported through the process. In addition to mandatory training, staff were expected to complete ‘essential training’ which was role specific and was delivered either via e-learning or classroom teaching.

Staff across community services completed competency passports to confirm they were competent to perform certain tasks independently. For example, the intravenous nurses were trained in cannulation and insertion of peripherally inserted central catheters and community nurses were trained in applying compression bandages for leg ulcers and changing tracheostomy tubes.

Data provided by the trust showed there were 39 registered general nurses had achieved the district nurse specialist qualification with a further three nurses undergoing the training and a further three to be trained in 2019/2020.

The trust told us they had introduced the ‘Care Certificate’ as part of the essential training programme to all non registered clinical new starters on induction and all existing staff to complete the course over time. The trust also funded staff to complete level 2 healthcare support worker apprenticeship that also covered competencies to the 15 standards of the Care Certificate. Data provided showed that four members of staff across community adults service had completed the ‘Care Certificate’. We observed this had been added to the risk register in December 2018 with the plan to allocate one member of staff per team per month onto classes starting from March 2019 onwards.

From April to November 2018, 94.6% of all required staff in community health services for adults received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff who received an appraisal</td>
<td>Individuals required</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>1</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>2</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>94</td>
</tr>
<tr>
<td>Other non medical staff</td>
<td>88</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>83</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>388</strong></td>
</tr>
</tbody>
</table>

**Multidisciplinary working and coordinated care pathways**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, other healthcare professionals, social workers and other local authority staff supported each other to provide good care.

There was a holistic approach to planning people’s discharge, transfer or transition to other services, which was done at the earliest possible stage. Staff across the community adult’s teams gave numerous examples of when they have referred, worked with and attended joint visits with other services from both primary and secondary care including specialist teams, therapists, clinical psychologist, the learning disability team, pharmacist and the local authority.

We also saw evidence of patients being referred or signposted to external services for support and advice and in one case for emergency admission.

Staff reported improvements to communication and patient care since the service had integrated. We saw evidence of multidisciplinary working and co-ordinated care within patient records we reviewed. Staff told us they attended multidisciplinary meeting with trust staff, but also external services. Examples included weekly meetings with GP’s, monthly neighbourhood delivery group meetings and frailty meetings with local authority staff and general practitioners.

Referrals to services were processed through a single point of access (‘community gateway’). Community gateway staff and the out of hours service were based at the same location as the integrated urgent care team, the extensive care service and out of hours team and staff told us this was useful if they needed to speak to staff within these services about a patient.

The community neurological rehabilitation team included therapy staff, specialist nurses, speech and language, psychologist and a consultant neurologist who reviewed complex patients monthly. In January 2019 the trust had set up a monthly Parkinson multidisciplinary clinic for patients to be reviewed by the Parkinson’s disease nurse, the speech and language team and the physiotherapist. Patients with Parkinson’s disease had access to a support group including therapy and psychological support.

Staff told us they also liaised with other health care professionals including the dietitians who based in the same building and with the Stroke and Parkinson’s Association.
Health promotion

Staff supported people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health.

Community adult services supported and motivated people to live healthier lives and improve their health and well-being. For example, patients with neurological conditions could access Pilates, line dancing and a balance and exercise group and there was a support group for those patients with Parkinson disease.

Patients were encouraged to become independent and self-administer subcutaneous medications such as dalteparin and insulin. Staff told us a self-administration advice leaflet explaining the process step by step had been devised to assist patients administering dalteparin and staff told us they were currently looking at developing one to support patients with the self-administer insulin.

As part of the neighbourhood development, each of the five neighbourhoods engaged with their local community around service redesign, community assets and health and wellbeing. As part of the service redesign teams initiated a 100-day challenge, for examples diabetes, frailty or chronic obstructive pulmonary disease (COPD). We observed storyboards from two teams that explained the topic they focussed on, the aim and outcomes achieved. Data provided showed that following the 100-day challenge around diabetes where 131 people attended events including health checks of those;

- 4 quit smoking
- 20kg in total weight lost
- 5 goals met around reducing alcohol
- 49% of people from two practices that were re tested were no longer coded as pre-diabetic.

During our inspection we observed health promotion advice including diet, exercise and smoking cessation being given during care and visible in patients waiting areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act. They could describe when to use it for patients who appeared to lack capacity to make decisions about their care.

During our inspection we observed that staff explained treatment plans and obtained verbal consent before performing any observations or providing patient care and this was documented within the patient’s records we reviewed.

There was a designated area on the community nursing initial assessment form for patients to consent to treatment. However, this was omitted on the short term assessment forms that were used for patients requiring two or less visits. We observed one short term assessment and did not see evidence throughout the record that consent was gained for care provided.

We reviewed three other records and found that consent had been ticked on the initial assessment.

Staff used their trust mobile phones to take photograph of wounds, these were printed and placed in the patients records and the image deleted from the phone. This allowed wounds to be recorded and monitored more accurately. We observed there were inconsistencies in the recording of consent to take a photograph for example, of a wound and we observed the 'photograph consent form' completed in only one of the two records we reviewed where photographs had been taken.
Following our inspection, we requested a copy of the policy for staff to follow with regards to consent when taking a photograph. The policy provided focussed on staff who were taking photographs on a trust site and stated that ‘staff must gain explicit written consent from the patient before the photograph is taken’. We also viewed the ‘consent policy’ that stated ‘expressed (verbal or written) was not required if it is taken for treating or assessing a patient and there was no possibility of the patient being recognised’. We are therefore not clear what guidance community staff should follow.

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

The trust set a target of 80% for completion of mental capacity act training.

From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 88.4% of all staff in community services for adults compared to the trust target of 80%.

A breakdown of compliance for mental capacity act level 2 training from December 2017 to December 2018 for all staff in community services for adults is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>37</td>
<td>39</td>
<td>94.9%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>108</td>
<td>126</td>
<td>85.7%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff were able to demonstrate an understanding of the Mental Capacity Act (MCA), best interests and when this would apply.

The community nursing initial assessments included a patient’s cognitive state. However, staff told us if they identified a patient who may lack capacity they would contact the GP or the social workers within the integrated care team to conduct a capacity assessment. Staff gave us examples of how they had liaised with other health care professionals and managed patients without capacity.
Is the service caring?

Compassionate care
Staff cared for patients with compassion and a caring manner, treating them with dignity and respect. Staff we spoke to were passionate and proud about the care they provided.

All the patients we spoke with were positive about their care and treatment. Comments included ‘can’t fault the staff at all, I would be lost without them’.

Patients dignity was always maintained, and we observed that curtains or doors were closed within clinical areas when staff were providing care and conversations were discreet within reception areas.

Staff members displayed understanding and a non-judgemental attitude towards (or when talking about) patients who had specific needs for example, mental health needs, learning disabilities or dementia.

Emotional support
Staff were caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.

Staff supported patients with their emotional needs and we observed staff listening and speaking with patients and their relatives in a supportive and reassuring way. Patients were complementary about the emotional support they had received.

Throughout each visit we observed, staff ensured patients understood what was happening and encouraged them to get in touch if they had any concerns.

A team leader told us a community nurse and a student nurse had stopped to support and stop a distressed member of the public from jumping off a bridge. The staff were presented with a ‘dignity award for professionalism in recognition of what they did.

During our inspection we observed ‘thank you ‘cards and letters within the team offices. As part of the national intermediate care audit 2018, an overview patients experience was collated. Data showed 94% of service users felt they always had confidence and trust in the staff treating or supporting them during their episode of care and 97% felt they were always treated with respect and dignity by the service.

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 and we observed this during our inspection and the records we reviewed. Relatives and patients, we spoke with felt fully informed.

We observed friendly, caring and respectful interactions between staff and patients. Staff enabled and encouraged patients to complete tasks independently, where able.

Patients, families and carers gave positive feedback about their care and told us that staff were caring, responsive and supportive and one patient told us the nurse would bake them a cake. During our inspection we observed thank you cards from patients and families and staff shared examples of feedback received from patients who were grateful for what they had done.
Patients knew who to contact if required and we observed service specific contact details in patient’s homes.

Staff on the community neurological rehabilitation team told us they would signpost carers of patients who had had a stroke to the Stroke Association for support.

Data provided as part of the intermediate care national audit 2108, showed a high percentage of patients answered ‘yes’ to questions about understanding and feeling involved in their care; I felt involved in decisions about when my care from the community team was going to stop (90%), I was aware of what we were aiming to achieve (98%) and I was involved in discussions and decisions about my care, support and treatment as I wanted to (98%).
Is the service responsive?

Planning and delivering services which meet people’s needs

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.

The integrated services worked closely with commissioners, other external bodies and internal services to make sure it planned and delivered services according to the needs of local people. There were a number of innovative services that provided coordinated and provided integrated care to patients with long term, complex conditions or who were in a crisis in the community. These services were set up to avoid hospital admission, attendance and support early discharge so patients could be cared for within their home.

The integrated care teams included district nursing staff, social workers and therapy staff and these were based in the same office or location to allow for ongoing communication. The district nursing teams told us that the local authority staff would sometimes attend the safety huddles to discuss patients.

Some community services were available seven days a week, including the urgent integrated care team, community intravenous therapy team, in addition to district nurses services that were available 24 hours, seven days a week.

Staff told us, treatment room clinics had been available at weekends and evening, but due to poor uptake of appointments these were not longer offered. Clinics were located across the Tameside and Glossop area and we observed there was car parking available although at some locations there was a cost.

Services were provided to deliver care and treatment to patients to allow them to remain at home thus avoiding hospital admission.

In May 2017, the trust introduced a ‘Digital Health’ a telehealth service that provided visual consultations of patients in residential and nursing homes via Skype and avoid hospital attendance and/or admission. Advice was given to care staff who had all been trained to perform basic observations, such as blood pressure and pulse.

The service was in the process of updating the IT systems so carers who provided care in patients homes could also access the service. In addition, the service also worked in partnership with the local authority, so staff could call in and respond to patients who have a pendant alarm.

The ‘digital health’ team also act as a single point of contact for urgent referrals from GP’s triaging patients to the appropriate health care professional.

The digital health service were also undertaking a ‘hear and treat’ pilot with a national ambulance service. The digital health team monitored calls to the emergency ambulance service that were categorised as ‘non- urgent’ and attended patients to provide care and treatment thus eliminating the need to dispatch an ambulance and potentially avoiding hospital attendance.

The team had been shortlisted for the HSJ award. Physiotherapists were working within GP surgeries as part of a ‘first contact practitioner’ pilot to ensure appropriate patients for example those with musculoskeletal problems could be assessed and receive treatment immediately rather than seeing the GP and then being referred and waiting for physiotherapy.
The intravenous therapy team cared for all patients who lived within the Tameside and Glossop area and accepted referrals from out of area hospitals. The service provided care to patients in their own homes, for example, administering intravenous antibiotics as per the GP ‘cellulitis’ pathway. However, staff told us they were looking at introducing other pathways including intravenous therapies for hyperemesis and community intravenous diuretics.

In January 2018, the long term condition team became the extensive care service to prevent hospital attendance and/ or admission for adult patients with long term conditions. Referrals were discussed at daily multidisciplinary team meeting and weekly meetings were held to discuss and review every patient at 12 weeks. Staff told us the team would also review patients via the hospital record who re attended the accident and emergency department to identify if the team could have managed the patient differently.

The extensive care service used the patient activation measure (PAM) tool to understand a patients ability and confidence to manage their own health and wellbeing. Those patients who were identified as inactive or not engaged would have a specialised management plan and be referred for social prescribing. The social prescribing service was delivered by the voluntary sector and provided one to one support and confidence to address areas where there could be a barrier to managing their long term condition well including loneliness, welfare rights, isolation, substance misuse and mental, health and well-being. Data provided stated that the service was currently taking around 200 referrals a month from health and care practitioners.

Staff from community services including stroke team, intravenous team the extensive care team attended board rounds at the hospital to identify and discuss any potential patients that were suitable for referral into the service.

### Meeting the needs of people in vulnerable circumstances

The intermediate tier services within the community adult services provided care and support for the management of patients with long term conditions or complex physical health needs. This enabled patients needs to be met in the community setting and care homes, and wherever possible avoided the need for admission to hospital.

Staff had access to support and advice from services across the trust including the community learning disability team. However, there were no aids immediately available, for example pictorial aids, to support staff and patients during care. During our inspection we observed information and contact numbers displayed within a waiting area.

We saw in minutes from the programme leads meeting in February 2019 that dementia practitioners were to be rolled out in Hyde and Ashton neighbourhoods.

Staff and patients had 24 hour access to ‘LIPS’ who offered British sign language, interpreters and translators for patients whose first language was not English. Staff we spoke to were aware of the services and how to contact them, if required.

A number of patients were housebound or were disabled and the services gained access to their homes via key safes. These were set up in conjunction with the patient, their relatives or social care.

The urgent integrated care community team followed the ‘home first’ model to avoid unnecessary re-admission to hospital. The service provided holistic assessments and supported people in their homes who were in crisis situations or had experienced a rapid deterioration in their health and/ or social care needs. The team consisted of nurses, therapy staff, social workers and customer care coordinators who were available from 7am until 7pm every day of the week and the urgent integrated care community team worked 8.00am to 22.00pm. The manager told us anyone could refer to the service although around 70% of referrals were received from the hospital. Referred
patients were triaged and risk assessed and either seen within one hour (rapid crisis), same day (urgent) or within 48 hours (urgent).

The frailty and falls programme was introduced as part of the health inequalities scheme that aimed to improve outcomes, patient experience, deliver value for money and establish a long-term sustainable service. The frailty programme was a multidisciplinary approach to identify severely and moderately frail patients early by completing falls and frailty risk assessments such as the GP frailty index, FRAT (falls risk assessment tool) score and Q fracture score.

There was an Asylum Seekers Service for refugees to access within the first 12 months of their arrival to Tameside. The service coordinated care, identify health needs, signposted individuals to appropriate services along with offering support.

A wide range of advice was available on the trust website for patients with specific concerns or diagnosis. We also observed leaflets in some of the areas we visited, and staff told us these were available in other languages or formats for example braille or audio.

**Access to the right care at the right time**

People could access community health services for adults when they needed them. Waiting times from referral to treatment were significantly better than all the national targets and met most of the locally set targets.

Referrals to services were processed through a single point of access (‘community gateway’) that was available seven days a week from 7am until 6pm. The out of hours team triaged calls from 6 pm until 10:30 pm and from 10:30 pm until 7 am calls were directed to the on call GP service. Referrals were received from patients, relatives and clinicians, including hospital discharge teams. Information relating to the patient was processed and triaged using set algorithms and patient’s details were either sent on to specific teams to action, patients were signposted to the appropriate service or given an appointment to attend a local clinic.

For the period from 1 November 2017 to 31 October 2018, the district nursing teams achieved a median time from referral to initial assessment of one day. The median time from assessment to treatment was also one day. The trust had no set local target and stated the response was based on individual patient need.

Referrals to the community neurological rehabilitation team were received from health care professions including GP’s within Tameside and Glossop area and hospital staff. However, patients who were known to the service could re refer themselves back into the service.

The community intravenous team had access to the hospitals electronic system which allowed the review of bloods taken in the community team and address any issues identified. The bloods were also reviewed as part of the weekly multidisciplinary meeting with the microbiologist.

The trust provided the following data on the largest Black and Minority Ethnic (BME) groups within the trust catchment area of Tameside.

The largest ethnic minority group within the Tameside area is White European with 2.4% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First largest
White Europeans 2.4%

Second largest
Asian British: Pakistani 2.2%

Third largest
Asian British Bangladeshi 2.0%

Fourth largest
Asian British: Indian 1.7%

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’ and provided data based on the period from November 2017 to October 2018.

The target was met for all teams with a set target for time from referral to initial assessment and for time from assessment to treatment within community health services for adults.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Time from referral to initial assessment</th>
<th>Time from assessment to treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>National / local target</td>
<td>Actual (median)</td>
</tr>
<tr>
<td>Tameside General Hospital</td>
<td>Acute dietetics service</td>
<td>1 - 3</td>
<td>1 day</td>
</tr>
<tr>
<td>Selbourne House</td>
<td>Community Dietetics</td>
<td>-</td>
<td>35 days</td>
</tr>
<tr>
<td>Selbourne House</td>
<td>Community Neuro Rehab Team</td>
<td>-</td>
<td>20 days</td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Community physiotherapy</td>
<td>18 weeks</td>
<td>32 days</td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Community Podiatry</td>
<td>-</td>
<td>34 days</td>
</tr>
<tr>
<td>Union Street Clinic</td>
<td>Continence</td>
<td>-</td>
<td>20 days</td>
</tr>
<tr>
<td>Crickets Lane Health Centre</td>
<td>Extensive care team</td>
<td>14 Days</td>
<td>8 days</td>
</tr>
<tr>
<td>Crickets Lane Health Centre</td>
<td>IV Therapy</td>
<td>-</td>
<td>1 day</td>
</tr>
<tr>
<td>Crickets Lane Health Centre</td>
<td>Long term condition service</td>
<td>2 weeks</td>
<td>5 days</td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Musculoskeletal podiatry service</td>
<td>18 weeks</td>
<td>35 days</td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Musculoskeletal physiotherapy</td>
<td>18 weeks</td>
<td>33 days</td>
</tr>
<tr>
<td>Ashton Primary Care Centre</td>
<td>Pulmonary rehabilitation</td>
<td>18 weeks</td>
<td>76 days</td>
</tr>
</tbody>
</table>
During our inspection physiotherapy staff told us that an advanced practitioner had been recently been employed to screen and triage patients to help reduce physiotherapy waiting lists as there was currently an eight week wait for routine referrals and a two to three week wait for urgent referrals.

Patients accessing the community neuro rehabilitation team were seen and triaged within expected timelines following referral. However due to staffing, patients then had to wait to see the appropriate health care professional within the team.

The senior manager told us that although all patients were triaged within the expected time, the service was using hospital staff for support and were advertising for a locum to work and decrease the time patients were waiting to be seen by the healthcare professional.

### Learning from complaints and concerns

Patients and relatives could raise concerns in various ways including via the trust internet site, email, in writing, in person or over the phone. The trust internet site and complaints leaflets that were available in clinical areas and patient records explained the complaints process along with support from the Patient Advice and Liaison Service and the NHS advocacy service.

Staff were aware of the complaints process and told us these were discussed within their teams. Staff told us they would escalate any verbal complaints to the team leaders who would try to address issues immediately. Managers investigated and responded to any formal complaints and fed back to the team leaders who would share with staff at team meetings.

From December 2017 to November 2018 the trust received 12 complaints in relation to community services for adults (2.8% of total complaints received by the trust). The main subject of complaints was clinical treatment (six).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>6</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
</tr>
<tr>
<td>Patient Care</td>
<td>2</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

For the seven complaints that had been closed at the time of data submission, the trust took an average of 28.6 working days to investigate and close these. This is in line with their complaints policy, which states complaints should be closed within 45 working days.

The five complaints that had not yet been closed had been open for an average of 31.6 working days at the time of data submission.
From November 2017 to October 2018 there were 323 compliments received for community services for adults (2.4% of all received trust wide).

Compliments were received in all 12 months of the period. July 2018 was the month where the most compliments were received (76).

The trust did not provide a breakdown by subject for compliments received.

**Is the service well-led?**

**Leadership**

Managers at all levels demonstrated high levels of experience, capacity and capability needed to deliver high quality, sustainable care. All managers had a deep understanding of issues, challenges and priorities in their service, and beyond.

Community adults services covered the five integrated neighbourhoods comprising staff from the division of intermediate tier services. The service was led by a service director supported by the head of nursing, directorate manager and senior operational and clinical managers.

The head of nursing was new to the trust, but the service director had previously worked at Tameside and had recently returned to the trust.

The majority of staff spoke very positively about their immediate managers, describing them as supportive and always accessible and approachable with an open-door policy. We were provided with examples of staff being supported with flexible working patterns.

During our inspection, we observed positive working relationships across all teams. Staff we spoke to knew and were aware of the executive team and senior managers. Data provided by the trust, showed that the chief executive and senior managers had on occasions visited different areas and services including community adults. However, a few members of staff felt the executive team were not very visible.

Staff told us the senior managers were visible and frequently visited their departments.

**Vision and strategy**

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

The integrated care trust strategic plan included community adult services in its ambition to ‘improve health outcomes for the population and influence wider determinants of health through collaboration with our health and care partners’

The vision for the service mirrored the strategic plan “to significantly raise healthy life expectancy across Tameside and Glossop.”

Community adult services were part of the Tameside and Glossop Integrated Care Model which was split into five neighbourhoods: Ashton, Hyde, Glossop, Denton, Audenshaw and Droylsden and Dukinfield, Mossley and Stalybridge.
The five Integrated Neighbourhoods were each led by a neighbourhood manager and a GP lead whose roles were to work collaboratively with primary care and neighbourhood staff. Each of the five integrated teams included adult social care, community services and the voluntary sector with each having set priorities based on their health inequalities such as heart disease or diabetes. Staff were able to demonstrate knowledge around the ‘the priorities’. The programme leads meetings discussed and reviewed the priorities and health inequalities and actions taken to address.

The Care Together transformational scheme 2019-2020 included ‘health inequalities’ together with frailty and falls and new models of care services. The new models of care services each had their own remit and objectives and included the digital health service, community response service, integrated urgent care team, extensive care service and the neighbourhood pharmacy team.

Staff we spoke to were aware of the vision and plans for the service.

Culture

Managers promoted a positive culture that supported, valued and motivated staff, creating a sense of common purpose based on shared values.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns.

Team leaders shared examples of when staff had gone the extra mile to support each other. For example, the evening service were offered help by day and off duty night nurses to visit patients near their own home when there was snow during the evening. A manager told us they had ordered pizzas in for their team to have following a team meeting.

The vast majority of staff felt respected and valued by their peers and managers and shared examples of why they felt this way, for example, a member of staff who had found a deceased patient at home was acknowledged for their caring and professional manner but was also felt well supported when they returned back to the clinic.

In response to issues raised about communication and engagement, by staff working within the service, the trust introduced cultural barometer surveys, staff engagement meetings and ‘house rules’ that were identified for staff, by staff.

During our inspection, staff told us about and we observed the ‘house rules’ displayed in staff areas. We also observed the trust ‘everyone matters’ and the values and behaviors; safety, care, respect, communication and learning visible at all locations we visited.

All staff we spoke to were passionate and proud of what they did and the care they provided and felt the integrated care approach had a positive impact on the patient.

The out of hours team leader told us the trust was currently reviewing the lone worker policy as they had identified it was focussed mainly for staff within the hospital setting. Community staff did not have personal alarms or torches, but were provided with mobile phones. Each team we spoke to had a ‘safe word’ they used when they made contact with colleagues to highlight they were in danger. The team leaders had a list of all visits each member of staff had and we were told if there was any concern about the visit, two nurses would attend.

We observed teams had a form completed of each member of staff documenting their characteristics, car details and next of kin. There were always two staff visiting patients in the dark or after 8pm. The out of hours team leader had built up a rapport with the local emergency
services and shared examples of when they had come to assist, for example when a staff members car was broken into and the fire brigade offered to take a nurse to a diabetic patient during adverse weather (snow).

Other services including social care services, wardens and out of hours GP services with access to off road vehicles who also helped staff who could not get to patients due to adverse weather conditions.

**Governance, Risk management and quality measurement**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

The service worked closely with the integrated care teams to identify and monitor performance, patient outcomes and expenditure. Patient outcomes, performance and finances were discussed at risk committees and the programmes leads meeting held monthly.

The governance structure had recently changed with community adults no longer within the medicine directorate. A separate division for community, intermediate tier services had been established. Senior managers told us key governance meetings including operational, finance and quality and safety were now also separate.

Management processes were in place to ensure there was escalation and the cascading of information to and from the senior management team to frontline staff. All staff were able to describe the structure and understood their role and responsibilities and the role of others.

The managers and team leaders we spoke with knew about the quality issues, priorities and challenges within the service.

There were effective systems in place for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected.

The service had a risk register with clinical and operational leads responsible for each risk relating to their team. Risks were reviewed and discussed at monthly risk summit meetings.

We reviewed the risk register and saw that each risk had an accountable person, date of review, actions taken to mitigate the risk along with the date the risk was added to the register. The majority of risks documented were potential incidents or issues that may occur rather than a current actual risk. For example, ‘a risk that patients may receive sub-optimal care and / or staff may not be adequately trained to undertake duties if they are not compliant with mandatory training’.

Risks documented also included potential risks due to staffing levels and lone working across different teams. It was not clear when some of the risks had last been reviewed.

We observed that some risks dated back to 2013. The highest risk score was 9 and these were related to the intravenous therapy team, with two of those not for further action or mitigation. Risks that were documented as ‘not for further action or mitigation’ remained on the risk register with a review date.

Senior managers we spoke with told us these risks should be removed from the register and they were currently reviewing how risks were managed and documented on the risk register.

There was a process for the escalation of information and sharing from staff within services up to and down from the trust board. The chief executive held monthly team briefs with divisional leads who then shared information to staff within their service.
Information relating to risk and performance was escalated from the services to trust board through meetings, for example, team leader meetings and divisional, quality and safety board meetings.

The service director and neighbourhood leads attended the monthly programme leads meeting that reviewed the priorities and health inequalities projects, financial impact and identified any risks or issues within the neighbourhoods.

The divisional quality and safety board meeting was a sub group of the trust’s quality and governance committee that reported up to the trust board. Divisional, quality and safety board were held monthly and reviewed key governance including risks, incidents, complaints, policies and changes to national and local guidance. The meetings were attended by the service director and managers. We reviewed a selection of minutes from the meetings and saw review of reports across the directorate, feedback from other committees, sharing of patient experience and identified issues that were escalated to the trust quality and safety committee.

The team leader meetings were chaired by the head of nursing and held twice a month. We reviewed minutes from two team meetings and observed key governance issues were discussed as part of a set agenda that included education, team updates, feedback from divisional committees, audit and issues to escalate to the directorate manager.

Each service had improvement action plans that were reviewed monthly by senior managers and managers at continuous improvement meetings. We reviewed three sets of minutes and observed action plans were reviewed and risks identified. A responsible person was assigned to actions requiring follow up and an action log was a set item on the agenda. However, we observed on all the minutes we reviewed, assigned actions did not always have target dates therefore it was unclear whether actions were expected to be addressed within a timely manner.

Senior managers told us they met weekly to discuss any issues and performance. However, this was informal, and no minutes were taken they felt it was important to meet up.

**Information management**

The service had recently introduced a district nursing service and neighbourhood dashboard that had been developed in collaboration with colleagues, commissioners and public health. The dashboard was devised to assist the service to monitor trends, patterns of performance and plan neighbourhood priorities.

We reviewed the dashboards and saw a clear monthly overview of activity of all services including clinical and non-clinical data for example patient activity, utilisation, information related to deprivation indices, demand and activity. Managers and team leads had access to it and we were told this was currently under development to include more outcome data.

**Public Engagement**

Services were developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches were used to gather feedback from people who use services and the public.

Since April 2016, the trust had acquired community services and had engaged with services within the community setting including mental health, social care and the voluntary and community sectors and patients to identify new models of care and health priorities.
The neighbourhoods worked collaboratively with other organisations to engage with patients and arranged events held in the community. For example, 100 people attended a free ‘afternoon tea for frail patients’ where the patients were given the opportunity to feedback regarding what local community activities, including exercise classes and social activities they would like to improve their health and mobility. Data provided also showed a total of 90 people attended a chronic obstructive pulmonary disease (COPD) event held at two separate locations. Another example of engagement included the ‘100-day challenge’

Senior managers told us they had submitted a bid for three additional band six staff to support new projects, for example working with care homes to address care needs.

The Patient Engagement Network (PEN) engaged with people and stakeholders of Tameside & Glossop through various media; face-to-face forums; conferences; PEN Newsletters (Involve). Along with general engagement around the effects of national priorities, areas covered through the network included neighbourhood development and service re design.

Data provided showed there was regular engagement throughout the year ranging from conditions for which over-the-counter items should not routinely be prescribed (June 2018), improving access to primary care (June 2018) and social prescribing and asset based community development (February 2018).

We saw evidence that the service worked with other organisations to engage and support carers at arranged events for example over 150 people attended friends of frailty community events held over 3 days and 40 carers attended a carers rights day in November.

The service told us they collated feedback from people who had accessed their services via the ‘friends and family’ test. The service did not provide any data regarding the results. However, they stated they had responded to negative feedback and had made changes to improve patient choice in appointment times and location. No further negative comments have been received.

**Staff Engagement**

The services engaged with staff to plan and manage appropriate services and collaborate with partner organisations effectively.

The trust engaged with staff by introducing ‘work perks’, the ‘speak out safely’ campaign, health and well-being campaigns and regular communications such as Team Brief and weekly ‘Catch Up with Karen’.

District nursing teams told us each team had a generic email and information was shared. One team leader told us to ensure ‘important’ information such as medical device alerts were read, they put a read receipt onto each email. We observed in minutes from the team leads meetings that alerts were documented as a set agenda.

Some staff told us they did not always have time to attend events or have time to read information sent out via emails. However, they felt they were kept informed at team meetings and safety huddles.

Community adult services were in the process of devising a staff engagement strategy (2018-19) to improve staff recruitment, retention and staff wellbeing. Staff from all services were invited to put themselves forward to represent their team where potential initiatives were identified and a survey was undertaken across the division. During our inspection, we observed that some teams had implemented some of the initiatives including sharing and celebrating good practice on social
media, team photos were visible in staff areas and the development of the 'house rules'. Teams collectively agreed the 'house rules' that were 'always' and 'never' events in their service, including how staff wish to be treated, and how they will treat others.

Senior manager told us 95 allied health professionals had attended a recently launched forum in addition to an allied health professional group that had representation from different leads across allied health professional services including pharmacy.

**Learning, continuous improvement and innovation**

There was a commitment to improving services by learning from things went well and when they went wrong, promoting training, research and innovation.

The trust acknowledged and recognised good and outstanding practice of individuals and teams by presenting awards. Teams we visited were proud to share with us that they and either been nominated or had awards such as ‘annual team awards’, ‘whose your hero’ award, ‘shining star’ award, ‘everyone matters’ and the ‘daisy award. During our inspection we observed certificated proudly displayed.

The service worked with a local university to research how neighbourhood team members experience the transition from traditional health and social care teams to integrated care systems.

The study was carried out with the Stalybridge neighbourhood team and we were told the results were positive with the team already taking an integrated approach. In addition, benefits to patients was noted due to reduced visits and more joined up care and communication.
Community health services for children, young people and families

Facts and data about this service

A list of the sites and teams that provide community services for children, young people and families at Tameside and Glossop Integrated Care NHS Foundation Trust is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Team name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Street Health Centre</td>
<td>Health visiting</td>
<td>Ann Street, Denton, Manchester, M34 2AJ</td>
</tr>
<tr>
<td></td>
<td>School nursing teams and family health mentors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Looked after children</td>
<td></td>
</tr>
<tr>
<td>Clarence Arcade</td>
<td>Early attachment team</td>
<td>Stamford St West, Ashton-under-Lyne, OL6 7LT</td>
</tr>
<tr>
<td>Crickets Lane Health Centre</td>
<td>Family nurse partnership</td>
<td>Crickets Lane, Ashton-under-Lyne, OL6 6NG</td>
</tr>
<tr>
<td></td>
<td>Health visiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>School nursing teams and family health mentors</td>
<td></td>
</tr>
<tr>
<td>Dewsnap Lane Clinic</td>
<td>Enuresis children and young people</td>
<td>Dewsnap Lane, Dukinfield, SK16 5AW</td>
</tr>
<tr>
<td>Droylsden Health Centre</td>
<td>Health visiting</td>
<td>Albion Drive Clinic, Albion Drive, Droylsden, Manchester, M43 7NP</td>
</tr>
<tr>
<td>Dukinfield Health Centre</td>
<td>Health visiting</td>
<td>Dewsnap Lane Clinic, Dewsnap Lane, Dukinfield, SK16 4LA</td>
</tr>
<tr>
<td>Hattersley Health Centre</td>
<td>Health visiting</td>
<td>Hattersley Primary Care Resource Centre, Hattersley Road East, Hattersley, SK14 3EH</td>
</tr>
<tr>
<td></td>
<td>Children's nutrition team</td>
<td></td>
</tr>
<tr>
<td>Hollingworth Clinic</td>
<td>ALD team</td>
<td>Market St, Hollingworth, Hyde, SK14 8HR</td>
</tr>
<tr>
<td>Hyde Health Centre</td>
<td>Health visiting</td>
<td>Hyde Clinic, Union Street, Hyde, SK14 1NX</td>
</tr>
<tr>
<td></td>
<td>School nursing teams and family health mentors</td>
<td></td>
</tr>
<tr>
<td>Mossley Health Centre</td>
<td>Health visiting</td>
<td>Market Place, Mossley, Ashton-under-Lyne, OL5 0HU</td>
</tr>
<tr>
<td>Rowan House Hyde</td>
<td>Child speech and language therapy</td>
<td>Grange Rd South, Hyde, SK14 5NU</td>
</tr>
<tr>
<td></td>
<td>Integrated services for children with additional needs (ISCAN)</td>
<td></td>
</tr>
<tr>
<td>Selbourne House</td>
<td>Paediatric dietetics</td>
<td>Union St, Hyde, SK14 1NG</td>
</tr>
<tr>
<td>Stalybridge Health Centre</td>
<td>Health visiting</td>
<td>Stalybridge Clinic, Waterloo Road, Stalybridge, SK15 2AU</td>
</tr>
<tr>
<td></td>
<td>School nursing teams and family health mentors</td>
<td></td>
</tr>
<tr>
<td>Tameside General Hospital</td>
<td>New fountain house - orthoptic and optometry</td>
<td>Fountain Street, Ashton-under-Lyne, OL6 9RW</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Sites tab)

Tameside and Glossop Integrated Care NHS Foundation trust provide services based on pathways led by three pathway leads and a family nurse partnership supervisor reporting to the head of children, young people and families.
The universal pathway is based on four geographically located, birth to 19 years of age, integrated healthy child programme teams. Each team is managed by band 7 team-leaders, who report formally to the Universal Pathway leads. The teams include the following staff: health visitors, school nurses (including immunisation and enuresis), family nurses, nursery nurses, family health mentors, children’s nutrition advisors and support workers aligned to the qualified team members. The core responsibility of the teams is the delivery of the Healthy Child Programme (DoH 2009) via universal, universal plus and partnership elements.

The partnership pathway provides services across Tameside and Glossop providing a named clinical link to each of the five localities. The teams include: the integrated service for children with additional needs (ISCAN), speech therapy, orthoptic and optometry services. The following staff make up partnership services: speech and language therapists, occupational therapists, physiotherapists, orthoptists, dietitians, nurses, learning disability nurses and appropriate support staff aligned to these professional team members. The core responsibility of the children’s teams will be the delivery of the birth to 25 years services for Special Education Needs and Disability (Children’s and Families Bill 2013) and the Healthy Child Programme via partnership plus elements.

The looked after children’s specialist team coordinate and support the delivery of looked after children assessments across children’s services. The remit of the team is supporting care leavers and looked after children residing in children’s homes. The team comprises of three nurses.

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS tab)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Community services for children, young people and families provided staff with training in safety systems, processes and practices and staff had a high level of compliance. Training was monitored by local managers and by the trust.

Training in community services for children, young people and families was conducted on induction and on a yearly basis and staff received refresher training.

Staff told us they received good training from the trust and told us that it was accessible.

Training was provided in a number of training modules which included, infection prevention control and manual handling and governance.

The trust set a target of 95% for completion of mandatory training. In 14 of the 19 training modules, staff in community services for children, young people and families reached this target. The lowest compliance level from the remaining 5 modules was 87% with the remaining over 90%.

Qualified nursing staff

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 for qualified nursing staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention</td>
<td>105</td>
<td>107</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>104</td>
<td>107</td>
<td>97.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>103</td>
<td>107</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>101</td>
<td>107</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>101</td>
<td>107</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 1</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>50</td>
<td>57</td>
<td>87.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall mandatory training compliance rate target of 95.0% for qualified nursing staff.

The 95% target was surpassed for three of the seven mandatory training modules for which qualified nursing staff were eligible. In three more the target was nearly reached and in one, manual handling, it reached 87.7%.

It should be noted that the training modules not meeting the target is due to only four to seven
eligible staff not having completed the training so the performance should be taken in context when dealing with small numbers.

**Medical staff**

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for medical staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community services for children, young people and families the overall mandatory training compliance rate was 100.0% for all courses in medical staff.

It should be noted that the mandatory training data relates to only five eligible staff so the performance should be taken in context when dealing with small numbers of staff.

**Qualified allied health professional staff**

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 for qualified allied health professional staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>36</td>
<td>37</td>
<td>97.3%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>33</td>
<td>37</td>
<td>89.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for children, young people and families the 95% target was met for five of the six mandatory training modules for which qualified allied health professional staff were eligible. Manual handling at level 2 did not reach the target with a compliance rate of 89.2%.

It should be noted that the training module not meeting the target is due to only four eligible staff not having completed the training so the performance should be taken in context when dealing with small numbers.
Safeguarding

Community services for children, young people and families directorate had systems to safeguard children and vulnerable adults from abuse. Services provided staff with policies to help keep people safe from abuse and this was monitored by managers. Staff had a high compliance rate for safeguarding training.

There was an overarching in-date safeguarding policy across all the trust and staff we talked to in the directorate knew it existed, had access to it and were aware of how it supported decision making.

Staff had a high compliance rate for safeguarding training. The trust set a target of 95% for completion of safeguarding training. In six of the eight training modules, staff in community services for children, young people and families reached the compliance target. In the other two modules the directorate were close to reaching the target. Safeguarding training included recognising and responding to female genital mutilation, domestic violence risks and child sexual exploitation. Staff had a policy on the failure to attend appointments by parents and gain access on home visits.

Staff demonstrated a good awareness of what to do if they had safeguarding concerns. The staff could explain what to do if they had concerns and who to contact.

We were told that staff in the department could seek expert advice from the trust safeguarding team if safeguarding issues arose. Staff told us all the safeguarding leads were accessible and based in the hospital.

The department was also supported by managerial leads who were trained at Level 4 children’s safeguarding. We were told that managers were accessible and based in the directorate.

The Trust are one of several organisations represented on Tameside safeguarding children’s board. The safeguarding board developed a new starter checklist which is used by members of staff working with children as part of their induction. The directorate follow this induction process.

All nurses in the directorate received individual safeguarding supervision and had access to group supervision as required. We were told by staff that therapist could ask for one to one supervision if problematic cases arose.

As part of the inspection we reviewed the directorates incidents evidence log 2018-2019. We saw evidence of how safeguarding incidents were shared across the directorates by the management and how these were fed into the named nurse for safeguarding to resolve or advise on. The learning log and actions to reduce the likelihood of further incidents were shared with all the directorate staff either by email or team meeting briefs.

Safeguarding Training completion

Qualified nursing staff

A breakdown of compliance for safeguarding training courses from December 2017 to December
2018 for qualified nursing staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>104</td>
<td>107</td>
<td>97.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>92</td>
<td>106</td>
<td>86.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for children, young people and families the 95% target was met for two of the three safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 was under the trust target rate of 95% at 86.8%.

**Medical staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 for medical staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Community services for children, young people and families had an overall safeguarding training compliance rate of 100.0% for medical staff.

It should be noted that the safeguarding training data relates to only five eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

**Qualified allied health professional staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 for qualified allied health professional staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the three safeguarding training modules for which qualified allied health professional staff were eligible. The target was not reached for safeguarding
children at level 3, however the rate was nearly reached at 94.3%.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Safeguarding referrals - adults

The trust did not report making any safeguarding referrals concerning adults within community services for children, young people and families from December 2017 to November 2018.

Safeguarding referrals - children

The trust did not provide a breakdown by core service for safeguarding referrals made concerning children. From December 2017 to November 2018, the trust made 3,754 safeguarding referrals concerning children trust wide to the Trust Safeguarding Children Team.

Looking at child safeguarding referrals across the 12-month period, overall there was a stable trend in referrals with peaks in January 2018 (381) and October 2018 (390).

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

Cleanliness, infection control and hygiene

Community services for children, young people and families’ directorate staff were aware of infection, prevention and control issues. The service controlled infection risk and staff kept equipment and the premises clean.

The trust had overarching procedures and a policy in place for its staff to manage infection control to minimise the risk to patients. Staff we spoke with in the directorate knew about the policy.

The department had access to a hospital lead nurse on infection control who provided expert decision making on issues which arose and supported audits.

All staff in the directorate had received training in infection control measures and training compliance was above the trust target of 95% reaching a completion rate of nearly 99%.

We saw four cleanliness audits for hand hygiene and bare below the elbow practice taken across the directorate over one year from April to April 2018-2019.

The services had high rates of compliance, with most of the 19 services in the directorate reaching 100% compliant in every quarter of the year. In the small number of services that were not compliant in some of the quarterly audits the lowest rate was 80% compliance.
On inspection, we observed hand gel being used by staff in all clinical areas and hand gel and paper towels were accessible above sinks in clinical rooms across the directorate. We also saw hand sanitising gel available in or near areas of care.

We observed that staff in the directorate followed ‘bare below the elbow’ guidance to minimise the risk of infection spreading.

Personal protective equipment such as aprons and gloves were available for staff to use across the directorate in clinical rooms when needed. We found sharps bins containing used needles and syringes were secure and safely stored.

Clinical rooms we reviewed across the directorate were cleaned by staff and cleaning staff on an ongoing daily basis and this was recorded for audit purposes. All reception and public areas we visited were visibly clean and tidy.

Appropriate flooring was used where examinations occurred or where procedures took place. The flooring was easy to clean, reducing the likelihood of infection.

Equipment in the rooms had been tagged to show cleaning dates and all the tags indicated that cleaning dates had been complied with.

Each clinical room had waste bins which were used by staff to dispose of clinical waste. Policies and procedures were in place to store and remove clinical waste safely.

**Environment and equipment**

We found that in most areas community services for children, young people and families directorate had suitable premises and equipment and looked after them well.

The directorate’s premises were a mixture of modern and older buildings. In a number of buildings, the interiors were tired and needed updating, but they were fit for purpose.

We saw electrical testing stickers on equipment, which indicated the equipment was safe to use and checked regularly.

Consulting and treatment rooms were of adequate specification and suitably sized. They contained the necessary patient equipment and stock, which was clean, in date and regularly checked by staff.

The directorate reviewed all specialist equipment with the maintenance department in the hospital.

We found two examples, in two different areas, where buildings had issues with central heating systems.

In the first building, Rowan House, which housed over 50 staff, we found that the central heating system had been inoperable for three months because the entire heating system was being replaced.

Because of the replacement, the building had no central heating from late December 2018 and was still without central heating at the time of our inspection in March 2019.

As a contingency, the trust’s facilities department had fitted electric heaters in a number of rooms in the building. The rooms had been designated as “hotspots” where clinical practice and administration could take place. The electric heaters were turned on by cleaners before opening hours so that rooms were warm.

The trust told us that the hotspots were created because having heaters in every room would triggered a power cut across the entire building.
Managers told us that whilst the situation was not ideal, patient care was constantly reviewed and clinics would be cancelled if patient areas were affected by the weather. We asked the trust to identify clinics that had been cancelled due to heating problems and they told us that no clinics had been affected by cancellation.

In the second building, Hollingworth Clinic which housed over 20 staff, we found that the temperature of the central heating system could not be adjusted in any of the buildings rooms. The heating was either fully on or fully off because the heating system did not have a temperature thermostat. We were told by the trust that Hollingworth clinic was not a clinical site where patients were seen, it only housed staff.

Due to the inability to control the heating temperature in the building, staff told us that at certain times throughout the year, rooms in Hollingworth clinic became hot and uncomfortable and windows had to be fully opened.

Staff and managers told us that this situation had been ongoing for three years since the directorate had started.

The heating system in Hollingworth Clinic was due to be replaced in March 2019, however there was a similar three-month period of replacement as in Rowan House.

It was obvious that the two buildings present state of repairs presented a challenge for staff and for some patient care.

We reviewed the departments risk register and Rowan House was not identified as a risk to the directorate. Hollingworth clinic was on the risk register.

We were concerned regarding the duration of time it has taken to replace Hollingworth Clinic heating systems. Whilst the trust told us patients had not been affected, staff in both sites have had to work in a poor environment over a prolonged period.

The staff have had to take their own measures to control and moderate the temperature of buildings, rather than the trust ensuring the environment was suitable for the staff.

We reviewed the directorates incident log and incidents regarding both buildings were low with no indication heating was a cause of incidents.

**Assessing and responding to patient risk**

We found that staff had the ability to assess and respond to patient risk in the children, young people and families directorate and were aware of who contact if deterioration occurred.

Documentation across the directorate showed that initial risk assessments were carried out for all children, young people and families who were referred to the services.

Assessments and care plans we looked at showed evidence that documentation included safeguarding and health information which kept children safe.

Staff told us that they would escalate concerns they encountered on their caseloads by speaking to supervisors or the safeguarding team located in the trust.

We found that buildings had first aid kits in them. If staff had any immediate concerns about an individual would contact emergency services immediately.

The directorate used threshold guidance developed by Tameside children’s safeguarding partnership, with which the trust was a party to.
The guidance was used as an assessment tool to enhance decision-making when a child, young person or family might need support. The guidance targeted four levels of support which at the lowest level might be referral to local community based services and at its highest-level escalation to child protection services.

The directorate also used a domestic violence nursing pathway assessment tool which was used by professionals to support individuals who were, at risk, or were the victims of domestic violence.

The directorate staff used an assessment tool which reviewed the risk of sexual exploitation for children under the age of 18 years old. If individual children were at risk they were referred to a multi-agency support service.

The directorate used a graded care profile risk tool which provides staff with an objective measure of the present care of children across all their areas of need. Staff could use this tool to assess the specific needs of children and use it to refer to organisations or agencies that could support children or families.

**Staffing**

The children, young people and families’ directorate had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The directorates levels of actual staff compared to planned staff were high.

During our inspection, staff told us that staffing levels had improved considerably in the last six months, but some staff still felt that for areas in Tameside, caseloads had become difficult to manage, due to complexity and numbers of families.

The fill rates for qualified nursing staff against the planned rates of staffing were over 92% and allied health staff rates were at 104% meaning that there were more staff than the trust had planned for.

Medical staffing was at 86% of its planned rates, but the directorate only had 4.7 whole time equivalent medical posts.

We found a good mixture of staff within teams with each profession complementing the other.

Vacancy rates by staff group in community health services for children, young people and families were overall higher than the trust target for vacancies and stood at 5.7%.

The figure for the two biggest staff groups were mixed, nursing staff vacancies were at 7.5% and higher than the trust target, but allied health professional staff rates were at 4.1% and therefore under the trust target.

Turnover rates by staff group in community health services for children, young people and families were generally higher than the trust target of 12%.

The figure for two biggest staff groups were mixed, nursing staff turnover was at higher than the trust target at 15%, but allied health professional staff rates were at 0%.

The directorate has a standard operating procedure for case management across it’s healthy child programme, which ensured that cases were shared equitably across staff and were managed safely.
Staff took responsibility as individuals for managing caseloads and a whole team approach ensured that workloads were shared equitably.

Designated roles were outlined in the policy and staff were informed of the processes they needed to undertake in that role. The policy ensured that staff were doing the job that was required of them rather than working outside of their role.

As part of designated roles, some staff groups, such as health visitors, provided duty health visitors who covered all enquiries coming into the service.

The duty process allowed pooling of staff resources so that teams were able to be more flexible and responsive to service needs, therefore enhancing the ability to achieve a high standard of service delivery.

All staff were expected to lead on a service area, so that quality and clinical effectiveness was enhanced.

The directorate provided us with a copy of the school health immunisation and children’s nutrition teams caseloads. We reviewed the evidence and found that caseloads were based on population needs in the team’s localities rather than simple staff numbers.

The directorate told us that expertise levels of staff were just as important as the numbers of staff in a team. Health visiting managers showed us evidence that they placed a senior health visitor in teams to assure a good balance of knowledge and support staff who had just joined team or were new in role.

**Qualified nursing staff**

The trust reported the following qualified nursing staff numbers for the two periods below for community services for children, young people and families:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>111.8</td>
<td>120.1</td>
</tr>
</tbody>
</table>

The trust reported a qualified nursing staffing level of 93.1% in community services for children, young people and families from April 2017 to March 2018. This decreased to 92.9% from April to November 2018.

From April to November 2018, there were 8.5 fewer whole time equivalent staff in post than planned for and 0.7 more whole time equivalent staff in post than from April 2017 to March 2018. There was an increase of 0.9 whole time equivalent planned posts between the two-time periods.

**Medical staff**

The trust provided the following statement regarding staffing data:

Medical Staffing consultant reflects whole time equivalent (Some consultants will show as 1 whole time equivalent even though they work more than 10 PA’s).

The trust reported the following medical staff numbers for the two periods below for community services for children, young people and families:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
</tbody>
</table>

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The trust reported a medical staffing level of 86.0% in community services for children, young people and families from April 2017 to March 2018. This increased to 100.0% from April to November 2018. It should be noted that the directorate only had 4 whole time equivalent medical staff employed at the time of the inspection so percentage levels could change drastically if one member of staff left.

From April to November 2018, there were 0.7 more whole time equivalent staff in post than from April 2017 to March 2018. The number of planned whole time equivalent posts remained the same between the two-time periods.

**Qualified allied health professional staff**

The trust reported the following qualified allied health professional staff numbers for the two periods below for community services for children, young people and families:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Qualified allied health professional staff</td>
<td>35.0</td>
<td>34.2</td>
</tr>
</tbody>
</table>

The trust reported an over established qualified allied health professional staffing level of 102.1% in community services for children, young people and families from April 2017 to March 2018. This increased to 104.0% from April to November 2018.

From April to November 2018, there were 1.4 more whole time equivalent staff in post than planned for and 0.7 more whole time equivalent staff in post than from April 2017 to March 2018. There was an increase of 0.1 whole time equivalent planned posts between the two time periods.

(Source: Universal Routine Provider Information Request (RPIR) – Total Staffing tab)

**Vacancies**

The trust set a 4% target vacancy rate. From December 2017 to November 2018, the trust reported an overall vacancy rate of 5.7% in community health services for children, young people and families. This did not meet the trust’s target.

Across the trust overall vacancy rates for qualified nursing and health visiting staff were 7.5%; for medical staff were 7.1% and for allied health professionals were -4.1%.

A breakdown of vacancy rates by staff group in community health services for children, young people and families at trust level is below:
Support to scientific, therapeutic & technical staff | -11.3% | Yes  
Qualified allied health professionals | -4.1% | Yes  
Other qualified scientific, therapeutic & technical staff | 0.0% | Yes  
Medical & dental staff - hospital | 7.1% | No  
Qualified nursing & health visiting staff | 7.5% | No  
Support to doctors and nursing staff | 12.0% | No  
NHS infrastructure support | 12.3% | No  
All staff groups | 5.7% | No

The negative vacancy rate for support to scientific, therapeutic & technical staff and qualified allied health professionals represents an over-establishment in these staff groups.

(Source: Universal Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover**

The trust set a target of 12% for turnover rates. From November 2017 to October 2018, the trust reported an overall turnover rate of 13.6% in community health services for children, young people and families. This did not meet the trust’s target.

A breakdown of turnover rates by staff group in community health services for children, young people and families at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Turnover rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>15.7%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>16.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>20.6%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>13.6%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness**

The trust set a target of 4.2% for sickness rates. From November 2017 to October 2018, the trust reported an overall sickness rate of 4.5% in community services for children, young people and families. This did not meet the trust’s target.

A breakdown of sickness rates by staff group in community health services for children, young people and families at trust level is below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual sickness rate (%)</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>0.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other qualified Scientific, therapeutic &amp; technical staff</td>
<td>0.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>2.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>3.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>5.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6.9%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>4.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Sickness tab)

Nursing – Bank and Agency Qualified nurses
From December 2017 to November 2018 the trust reported 120.0 of the 131,098.5 available hours were filled by bank staff (0.1%) and no hours were filled by agency staff for qualified nursing staff in community services for children, young people and families. There were 1,576.5 hours that needed to be covered by bank or agency staff but were left unfilled (1.2%).

The trust gave the reason of ‘vacancies’ for the usage of bank and agency staff.

A breakdown of bank and agency usage by team is shown below:

<table>
<thead>
<tr>
<th>Team</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Health visiting (all teams)</td>
<td>0.0</td>
</tr>
<tr>
<td>School nursing (all teams)</td>
<td>120.0</td>
</tr>
<tr>
<td>Total</td>
<td>120.0</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

Nursing - Bank and Agency Non-Qualified nurses
From December 2017 to November 2018 the trust reported that of the 46,176.0 available hours, none were filled by bank or agency staff for non-qualified nursing staff in community services for children, young people and families. There were 247.0 hours that needed to be covered by bank or agency staff but were left unfilled (0.5%).

The trust gave the reason of ‘vacancies’ for the usage of bank and agency staff.

A breakdown by team is shown below:

<table>
<thead>
<tr>
<th>Team</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Health visiting (all teams)</td>
<td>0.0</td>
</tr>
<tr>
<td>School nursing (all teams)</td>
<td>0.0</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Total</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

Medical locums
The trust did not report any medical locum usage in community services for children, young people and families from November 2017 October 2018.

(Source: Universal Routine Provider Information Request (RPIR) – Medical Locum Agency tab)

Quality of records
Staff in the children, young people and families’ directorate kept detailed records of patients’ care and treatment. We saw that records were clear and up-to-date and stored well.

The quality of records was good across the services. The records we reviewed were clear and concise in terms of interventions made by staff and the recording systems supported patient care.

The staff completed assessments on patients and followed a care planning process to evidence good care.

The directorate had developed a standard records audit procedure across its services which included inspection of records on one to ones with managers and where applicable, such as health visiting, audit against national standards.

We reviewed a school nursing record keeping audit of ten different records over 12 months from April 2018 to March 2019 which showed that out of 120 records reviewed across 26 areas, audit scores were generally above 95%.

We reviewed a health visiting record keeping audit of 8 different records over 12 months from April 2018 to March 2019 which showed that out of 96 records reviewed across 26 areas, audit scores were generally above 95%.

Medicines
The children, young people and families’ directorate followed best practice when giving, recording and storing medicines

The trust had a medicines management policy and staff within the directorate followed systems and practice in relation to the policy.

Medicines were prescribed by the community paediatrician or by the general practitioner. Medicines records were kept up to date for each child.

There was a system of checking and giving medicines to children in schools.

Vaccinations were delivered to school children by a bespoke school nursing team. We found procedures in place to order store and transport medicines and monitor maximum and minimum fridge temperatures. Nurses and staff in the service received immunisation update training,
Staff transported vaccines to schools using insulated bags' that were monitored with portable maximum/minimum thermometers. The bags kept medicines cool so that heat did not affect vaccines performance.

**Safety performance**

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 urinary tract infections in patients with a catheter from January 2018 to January 2019 within community services for children, young people and families.

*(Source: NHS Safety Thermometer)*

**Incident reporting, learning and improvement**

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.

From December 2017 to November 2018, the trust reported no incidents classified as never events for community health services for children, young people and families.

*(Source: Strategic Executive Information System (STEIS))*

Staff in the children, young people and families directorate recognised and could describe incidents and safety concerns appropriately, including near misses. When things went wrong, staff told us they would apologise and give patients honest information and suitable support. The directorate managed patient safety incidents well.

The directorate reported no incidents classified as never events and no serious incidents in the period December 2017 to December 2018.

Staff in services told us that there was an open culture where safety incidents could be raised and would be acted upon by managers and the staff team.

We reviewed incidents across the directorate and found numbers were low and of low seriousness and we found no pattern to the incidents that we reviewed.

Incidents in the directorate were recorded using an electronic incident reporting system. All staff we interviewed told us that they were trained to use the system and could gain access to it.

Staff across the directorate were aware of duty of candour. 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.
As part of the inspection we reviewed the directorates incidents evidence log 2018-2019. We saw evidence of how incidents were shared across the directorates by the staff group and how these were shared across the staffing structure. Learning was shared with directorate staff either by email or team meeting briefs.

In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in community health services for children, young people and families, which met the reporting criteria, set by NHS England from December 2017 to December 2018.

We reviewed 141 incidents reported by the directorate to the trust. The incidents occurred over the period March 2018 to March 2019.

We found that all the incidents reported were either insignificant or minor. Incidents were spread evenly across the directorate services and had no cause or pattern to indicate that an issue was systemic.

(Source: Strategic Executive Information System (STEIS))

From December 2017 to November 2018, trust staff within community services for children, young people and families did not report any serious incidents.

(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports relating to community services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – Prevention of future death reports tab)
Is the service effective?

Evidence-based care and treatment

The children, young people and families’ directorate provided care and treatment based on national guidance and evidence of its effectiveness. The services in the directorate used evidence based practice guidance which was reviewed on an ongoing basis.

The directorate used a number of pre- and post-assessment tools and guidance, which were comprehensive and based on national guidance. During the inspection we were provided with 16 National Institute for Health and Care Excellence guidance documents that the directorate use in the course of their work.

The assessments were coupled with a number of bespoke services which considered and improved the general health and well-being of families.

The guidance and service ensured that families immediate and ongoing needs were fully assessed and where appropriate this included their social, mental and physical wellbeing needs.

Services in the directorate reviewed their provision and updated guidelines within their care pathways on a regular basis.

We saw a number of examples of best practice and talked to the directorates health visitors, family nurse partnership and children’s nutritional team in our inspection.

Health visitors led and delivered the healthy child programme providing services covering pregnancy and the first five years of life.

The healthy child programme is a national evidence-based public health programme for children and young people. The programme provides a range of health interventions and support beginning in pregnancy and continuing through early childhood.

The programme has a national service specification which is published by public health England to inform commissioners about the components of a good health visiting service. The directorates managers told us that their health visiting service was named as an exemplar of national good practice in the specification.

The directorate’s family nurse partnership is a voluntary home visiting programme for first-time young mums and families. It supports families and helps them have a healthy pregnancy and improve children’s health and development. The partnership is underpinned by an international evidence base which has shown such partnerships can improve health, social and educational outcomes in the short, medium and long term, while also providing positive economic returns.

Health visitors in Tameside had been trained in new-born behaviour observation by the brazelton centre (a charity whose primary goals are to promote an understanding of baby behaviour and development and to foster strong infant-parent relationships).

New-born behaviour observation is a structured set of observations designed to help the clinician and parent work together, to observe the infant's behavioral capacities and identify the kind of support the infant needs for their successful growth and development.

The directorate was an integral part of the Tameside parent infant pathway. The pathway is a borough wide initiative that provides families with support and assistance through a network of evidence based family orientated services in the area.

As part of the pathway, the directorate were asked to participate and present their pathway findings to the world association for infant mental health at its international conference.

Nutrition and hydration
As part of the inspection we interviewed members of the children’s nutrition team. The team’s aim was to increase healthier food provision, healthier eating norms, and healthier food cultures in children’s settings, communities and families.

The team worked with families and family based organisations and, at the time of our inspection, it was providing teaching and training lessons to professionals across Tameside.

The children’s nutritional team followed guidance based on the National Institute for Health and Care Excellence standards C34G, PH9, QS94 PH49 and government dietary guidelines from the Department of Health. All the standards reflected best practice in behavioural change or dietary management. The children’s nutritional team also used case studies, evaluation and feedback forms to enhance

The baby friendly hospital initiative, is an evidence based programmed developed by the World Health Organisation and united nations children’s fund. The initiative is an effort to support mothers to breastfeed babies effectively and promote breastfeeding by enhancing the role of maternity services.

The programme encourages services to provide nutritional and breast-feeding advice to pregnant women, mothers at maternity services.

The directorate was assessed as fully accredited by the initiative in 2017, which meant staff received training and gave information to women and their families in line with best practice.

There were a collective of professionals in the directorate who provided a virtual infant feeding team all were trained in the initiative and provided additional support to parents when needed.

### Patient outcomes

The children, young people and families’ directorate service used a range of ways to gather information and evaluate performance against patient outcomes.

Managers told us of new outcome measures that were being developed to better demonstrate the positive impact of the care delivered.

The health visiting team measured their performance outcomes against delivery of the Healthy Child Programme and produced regular reports and national key performance indicators to monitor its progress. The healthy child programme outcomes were generally better or in line with similar sized services nationally.

The school nursing service also used national performance outcomes to show the effectiveness of its services against local and national targets, as did the asylum seekers team.

School nursing, school immunisation service and the asylum seekers team provided data from April 2018 to Sept 2018 which showed they were hitting both national and local targets.

We were told that some of the outcomes for the service were time sensitive and only evident after a prolonged period where children had reached adolescence, long after staff had been involved.

Whilst this was the case, a number of the directorates services such as the baby friendly hospital initiative, early attachment service and the healthy child programme had strong evidential positive outcomes which had been measured over time nationally and internationally.

During our inspection we saw evidence of an evaluation report on the children’s nutritional service. The report showed guidelines which underpinned the service and the types of training and the numbers of activities which had been provided to the public and organisations within Tameside.
Case studies were presented which showed how the service had worked with schools to develop healthy eating programs.

Information on outcomes was shared with commissioner’s and case studies and feedback from parents and children were also used to demonstrate patient outcomes.

We saw an audit which was undertaken by the directorate in March 2019 on its health visiting service which included a lead assessor covering 14 audit areas in ten case files. The questions covered the effectiveness of antenatal information, discussions with parents, number of baby clinic interventions, bonding and breastfeeding and referral to community support. The response was positive with 10 out of 14 areas in the audit reaching maximum scores.

We saw an audit was undertaken by the directorate in January 2019 on its health visiting service which included a lead assessor covering 18 audit areas in 20 cases. The questions covered the ante natal information, effectiveness of discussions with parents, number of baby clinic interventions, bonding and breastfeeding and referral to community support. The response was positive with 50 % reaching maximum scores and most of the rest nearly reaching maximum scores.

The directorates immunisation service provides vaccination against the human papilloma virus which decreases the risk of cervical cancer in later life for women. The vaccine is given to girls usually between the ages of 12 to 14 years of age.

Vaccination rates have significantly dropped across England in 2018. However, Tameside has the highest rate of vaccination in the whole of England in 2018 standing at 94.3%.

We saw an annual audit undertaken by the directorates children centre service which included a lead assessor covering six audit areas in 19 cases. The questions covered the effectiveness of, discussions with parents, help and support, bonding and breastfeeding and referral to community support. The response was positive with 5 out of 6 in the audit reaching maximum scores.

Whilst the directorate showed evidence of its effectiveness it had not participated in any clinical audits as part of the trusts clinical audit programme.

**Competent staff**

All staff in the community health services for children, young people and families directorate were appropriately qualified.

We were told by new staff members in the directorate, that they had received a good induction in the service and had been given time to do mandatory training on induction and participated in shadowing colleagues.

We saw health visitor’s induction and preceptorship packs. The pack provided new staff with a comprehensive training menu and a learning tool which was used by line managers, preceptors, preceptee to show how their practice had developed.

School Nurses and community nurses also had a preceptorship programme which provide a framework to review progress as newly qualified School Nurses.

Relevant professionals (medical and nursing) were registered with the General Medical Council and Nursing and Midwifery Council.

The trust governance and compliance team monitored medical staff and nursing renewal dates of registration, appraisal status, revalidation status and Disclosure and Barring Service status.
We were told by staff that managers appraised staff’s work performance. The trust had an appraisal target rate of 90% in its staff groups.

Figures provided to us by the trust confirm this. The lowest rate of appraisal in the directorate was 94.2% and the 100% rate of appraisal was reached in four of the six staff groups in the directorate.

We were told by staff that managers held clinical supervision and one to one meetings with them to provide support and monitor the effectiveness of the service.

Health visitors and school nurses undertook clinical supervision every six to eight weeks. Staff who have more specialist roles that supported very vulnerable patients could access a clinical psychologist for support every two weeks.

Formal supervision is provided to newly qualified nurses via preceptorship including informal monthly meetings/formal discussions at 3, 6 and 12 months post registration.

We were told that following any serious event, it would be normal practice for a debrief with teams effected to occur and this was undertaken and led by the most appropriate professional. Staff had access to counselling services as required.

Professional Midwifery Advocates provide coaching and restorative supervision to Midwives periodically.

Junior doctors in the directorate accessed supervision via a nominated consultant (included on the GMC register of accreditation) and the trust managed a live database. Consultants across the trust access clinical supervision via their clinical director.

**Appraisal rates**

From April to November 2018, 95.5% of all required staff in community health services for children, young people and families received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who received an appraisal</td>
<td>Individuals required</td>
</tr>
<tr>
<td>Other non-medical staff</td>
<td>8</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>41</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>5</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic, technician staff</td>
<td>1</td>
</tr>
</tbody>
</table>
Qualified nursing midwifery staff | 116 | 123 | 94.3% | 90% | Yes
---|---|---|---|---|---
Support to doctors and nursing staff | 65 | 69 | 94.2% | 90% | Yes
All staff groups | 236 | 247 | 95.5% | 90% | Yes

(Source: Universal Routine Provider Information Request (RPIR) – Appraisals tab)

**Multidisciplinary working and coordinated care pathways**

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 in the directorate spoke highly of other professionals and told us that joint working was key in providing holistic care.

We saw good examples of integration of staff groups.

An example of this was the children with additional needs service and the adult learning disabilities transitional team.

We visited these teams and staff worked together with patient’s families and the local authority over a period to ensure a consistent approach to service delivery.

The additional needs service therapists and clinical staff provided written contributions as part of the educational and health care plan, which was co-ordinated by the local authorities.

We saw different disciplines working together in children’s clinics and schools in a co-ordinated way to provide health care to children.

The directorate had developed bespoke training and awareness at a number of local forums across Tameside, these include: learning disability training for staff at the division of surgery, woman and children, which it was part of and staff at quality & safety forums across the trust.

The training supported multi-disciplinary work across the borough with other professional groups.

The leadership team in the directorate came from different disciplines which included therapy services and nurses.

The professional diversity of the leadership team clearly had an impact on staff teams. We found that all professions were valued and had a voice in the directorate and this was reflected in care pathways, case planning and team working.

**Health promotion**

The directorates health mentor service for young people, offered advice and support on issues that young people faced including: smoking, weight, alcohol and drugs misuse and emotional health and well-being.

The children’s nutritional service had developed numerous courses which improved the well-being of families across Tameside.

The nutritional teams Jumps4Life 5-13 was a 10-week multicomponent family weight management course for children and young people between the ages of five and 13 years of age.
This programme was accessible to all families with children who are above a healthy weight residing in Tameside, have a Tameside GP or attend a school within Tameside. This course offered support for families on healthy eating, keeping active and promote good self-esteem.
The team also provided a Nutrition and Oral Health Award for Carers of the Under 5’s. The award ensured that childcare providers in Tameside met national and local food, nutrition and oral health guidelines. Childcare providers who have gained the award were celebrated on Tameside MBC Early Years website.

A similar award was available to schools who participate in Food4Life. It was given to schools that show a whole school approach to the provision and promotion of healthy food. It also ensured that the food being served in school met School Food Standards and was primarily targeted at the 20% most deprived areas in Tameside.

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

The community health services for children, young people and families’ directorate sought consent to care and treatment which was in line with legislation and guidance.

Gillick competence is the term that is used to decide whether a child can consent to his or her own medical treatment, without the need for parental permission or knowledge.

We found staff were aware of the need to review the capacity and maturity of children to make decisions without parental consent. Staff were also aware of the need for parental consent when children were not able to provide consent themselves.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards.

Staff in the directorate worked on the principle of implied consent, but if written consent was needed, it was obtained.

Staff told us they would involve their safeguarding leads if they had concerns regarding a patient’s or parent’s capacity while attending the directorate services.

The trust set a target of 80% for completion of mental capacity act training. From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 72.0% of all staff in community services for children, young people and families compared to the trust target of 80%.

A breakdown of compliance for mental capacity act level 2 training from December 2017 to December 2018 for qualified nursing and allied health professional staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified allied health professional staff</td>
<td>17</td>
<td>23</td>
<td>73.9%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>
It should be noted the qualified nursing and health visiting staff group not meeting the target is due to only one member of eligible staff not having completed the training so the performance should be taken in context when dealing with small numbers of eligible staff.

The trust did not provide any training data relating to medical staff completing mental capacity act training in community services for children, young people and families.

(Source: Universal Routine Provider Information Request – Training tab)
**Is the service caring?**

**Compassionate care**

We found that staff in community health services for children, young people and families consistently demonstrated compassion, kindness and respect towards children, parents and their families.

Staff that we interviewed recognised the economic and social challenges faced by parents and families they worked with. Staff were also aware of personal, cultural, social and religious needs of children and their families.

The staff demonstrated a joined-up approach to health care which included a passion to improve the social and economic well-being of all the families they worked with.

Staff understood the anxieties of parents and children. We observed many interactions where the staff responded with compassion, in a supportive way, explaining treatment or supporting parents to enhance the care of their children.

Staff interacted well with children both on a physical level and by talking to them appropriately. We listened to staff being supportive and sensitive in their communications with patients and children.

Data submitted to the friends and families April 2018 to March 2019 showed that of the rates of satisfaction for most services was over 90%.

In the most recent health visitor survey undertaken in 2018 by the directorate, 98% of 251 responses said they were treated with respect and dignity.

The integrated service for children with additional needs also undertook a survey which was conducted by the University of York. It found that 19 of the 24 families who participated, felt they received the support they needed all the time. The remaining four families said they received the support and care they needed often and sometimes.

The staff promoted confidentiality in their communication with patients when needed. Confidential personal information was not discussed for others to hear at reception desks and information on patients was not visible. Patients and relatives could have private conversations with staff in consultation rooms when needed.

Patients and their relatives told us staff always treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.

Feedback from people who used the service, and those who were close to them was continually positive about the way staff treated people. Parents told us their consultations had been positive and that staff provided them and their children with good care.

**Emotional support**

Staff ensured that people’s emotional health and wellbeing were considered as part of their care and treatment.

Parent groups and mentor groups were in place throughout the service so that further advice and support could be provided to parents who experienced challenges due to caring for their child’s needs.
The children's nutritional team were often involved in difficult discussions regarding weight and obesity. The service supported children and parents who faced stigma and told us how they had difficult discussions with families in a way that was emotional supportive to the family unit.

Staff across the directorate received a range of compliments about the care they provided from parents. Service users provided positive feedback about staff members who had enabled them to achieve their aims in supporting their families.

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

The family nurse partnership and the health visiting service have made a concerted effort in widening engagement with fathers in their contact with families.

Health visitors now screened partners, as well as mothers, for mental health issues as part of the perinatal pathway.

The family nurse partnership made 1207 visits in the year period 2017-2018 and 63.5% of the visits delivered to clients in pregnancy included high levels of partner involvement.

The directorate had conducted surveys in its health visitor and integrated service for children with additional needs services. The surveys showed that the directorate had a positive and supportive link with its patients and family members.
Is the service responsive?

Planning and delivering services which meet people’s needs

Community health services for children, young people and families services were provided in a variety of locations, including family homes, schools, local clinics and primary care centres. Appointment times varied throughout the day so that parents and families had choice.

The directorate met the needs of local people and, where challenges occurred, had started to develop systems so that deployment of staff was effective in high and low population areas.

Buildings in the directorate were accessible to the public and to patients. Patients and staff with mobility problems had access to buildings via access ramps and lifts and the building’s in the directorate had disabled toilets and wide waiting areas and suitable chairs.

As part of the directorates reporting process, a number of services including speech and language therapy and health visiting, had developed hotspot reports which were soon to be replicated across other services.

The reports show the type of service provided to the population and locality area where the contact took place. The age profile was also used to identify trends.

The reports enabled services to target the services resources to localities. The speech and language therapy report we had sight of clearly showed how national deprivation scores in some localities matched increase in demand for the therapy service. The report could therefore be used to highlight where further partnership resources might need to be targeted.

The reports were used in conjunction with caseload reviews to ensure the right resources were put into a locality.

The school health service used a document that looked at the children’s need levels in schools so that they could match need with resources. The document included social care as well as educational needs.

The health visiting service conducted a client satisfaction survey in June 2018. The survey consisted of a number of questions based on three areas which were; speed of access, effectiveness and overall satisfaction.

The survey had 251 responses from families and overall 97% of all respondents recommended their health visitor. The responses also showed a 99% positive response across the three survey areas.

The only area which did not reach this mark was 85% response to the question “did they strongly know how to make a complaint”. The question feedback form showed only 7% did not know how to access the service.

The directorate staff had access to an interpreter service so that there was clear communication with patients who needed it.

Meeting the needs of people in vulnerable circumstances

Community health services for children, young people and families provided people with personalised care which was responsive to individual’s needs. The services offered new flexible services and had introduced new clinical pathways.

The directorates teams inputted into a variety of multi-agency assessments and interventions through: person centred care plans, early help assessments, early help panels, special education need and disability panels, health and care plans and case conferences.
The directorate provided us with information on its antenatal and post-natal mental health guidance which introduced screening procedures and pathways for its health visitors to follow in conjunction with the trust’s maternity department.

Perinatal mental illness affects up to 20% of women who give birth and covers a wide range of conditions at both the pre- and post-birth stages.

Serious perinatal mental health problems can be a significant risk to women in terms of harm and can have significant and long-lasting effects on the family. Health visitors in Tameside can access a wide range of services for parent’s dependent on family need, from low threshold listening services to specials acute services dependent on need.

The perinatal pathway supported health visitors and other professionals to assess and respond to mental health issues in families on their caseloads and had been developed using clinical management NICE guidelines.

The directorate had a midwife with special interest in perinatal mental health, who provided training on parent-infant mental health with the early attachment service and delivered multi-disciplinary training for social workers, health visitors and midwives.

The directorates early attachment service worked with families and helps parents build a strong relationship with their baby so that their baby feels safe, secure and happy. The early attachment service focused on health promotion and promoted bonding between parents and children up to three years of age using attachment theory and an early intervention model. The early attachment service worked across the Tameside area.

Attachment theory is based on evidence that a child whose first experience is of a loving relationship with a reliable caregiver will later function as a balanced human being. Research has shown that more than 40% of families with 0-3-year olds could experience some degree of difficulty with parent-infant attachment. The figure translates to over four thousand children in the Tameside area.

The early attachment service operated at different levels with families depending on the complexity of work undertaken and relied on training health visitors and midwives to intervene early, particularly with this 40% identified in the research.

The model involved the directorates health visiting service working closely with a small, specialised early attachment team. The team consisted of clinical psychologists and health visitors.

The attachment team worked on a tiered basis dependent on the need of the parent. At a universal level, parents across Tameside were provided with information for all new and expectant parents, in the form of a booklet and DVD ‘Getting it Right from the Start’ which was available from midwives or health visitors. The content was also available on the internet.

During the inspection we visited the integrated service for children with additional needs team and the adult learning disabilities transitional team, who had commenced closer working relationships including the inception of some joint pathways which came under the umbrella of a whole life pathway.

Staff from both services worked together with patients and families over a period of time to ensure a consistent approach to service delivery across children and adults services. We were told by staff and managers that the work entailed planning for the child or young person’s future aspirations as an adult, as well as their current needs as a child.
The integrated service for children with additional needs team staff offer treatment and support to young people with an additional need and or complex health need.

The services therapists and clinical staff provide written contributions to individuals educational and health care plans, which are co-ordinated by the local authority. An education, health and care plan is for used for children and young people aged up to 25 who need more support than is available through special educational needs support. The plans identify educational, health and social needs and set out the additional support to meet those needs.

The directorates additional needs team had contributed to 212 education and health and care plans between 1 August 2017 and 31 July 2018. The number was an activity increase of over 2000%.

“Holding the baby in Mind”, is another part of a parent infant pathway which the directorate provided services in. As part of the pathway, home start volunteers were attached to individual families for a four-week period.

The volunteers were supervised and supported by home start and health visitors provided training. The service supported families with low threshold needs, so that families did not escalate to become vulnerable and needing greater support from statutory services. The service was also an effective way of using local community resources to free capacity in health visiting caseloads.

Access to the right care at the right time

The trust provided the following data on the largest black and minority ethnic groups within the trust catchment area of Tameside.

The largest ethnic minority group within the Tameside area is White European with 2.4% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Europeans</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian British: Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian British: Bangladeshi</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian British: Indian</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – Accessibility tab)

The delivery of the healthy child programme is monitored by the directorate. The health visiting service had several key performance targets which related to the healthy child programme.

The targets reflected health visitor contact with families at vital key stages of child development which included contact at the antenatal stage all the way through to a 2-year development assessment.

The trust provided us with the performance report for its health visiting service which showed performance from April 2017 to December 2018.

The report has 36 performance traffic light examples all against the healthy child programme targets.
The green traffic light meant that the service was above the national target and above the benchmark, which is achieving higher rates than services which were similar in size and composition.

The amber traffic light meant that the service was only below the national target, but above its benchmarked services.

The last traffic light, red meant that it was below the national target and its benchmark.

We found that overall the service was green in 17 of the 36 areas, amber against 19 and red against six of the 36 outcomes.

The directorate provided key performance targets for its asylum seekers service, school nursing and school immunisation service from April 2018 to Sept 2018. School nursing and school immunisation achieved all their 9 national community targets across both services in this time.

The asylum seekers service hit its national target in this period which was that referrals received an initial health screen within 30 days.

The trust identified the below services in the table as measured on ‘referral to initial assessment’ and provided data based on the period from November 2017 to October 2018.

There was no set target for any of the teams/services for time from referral to initial assessment within community health services for children, young people and families.

The directorate had long waiting times in child speech and language therapists team and in the integrated service for children with additional needs team.

The trust did not provide data on days from initial assessment to onset of treatment within community health services for children, young people and families.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to initial assessment Actual (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann street health centre</td>
<td>Safeguarding service</td>
<td>34</td>
</tr>
<tr>
<td>Crickets lane health centre</td>
<td>Asylum seekers</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Family nurse partnership</td>
<td>20</td>
</tr>
<tr>
<td>Dewsnap lane clinic</td>
<td>Continence under 19</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enuresis children &amp; young people</td>
<td>76</td>
</tr>
<tr>
<td>Hattersley health centre</td>
<td>Children’s nutrition team service</td>
<td>55</td>
</tr>
<tr>
<td>Hollingworth clinic</td>
<td>Adult learning disabilities</td>
<td>33.5</td>
</tr>
<tr>
<td>Rowan house health centre</td>
<td>Child speech and language therapists</td>
<td>131</td>
</tr>
<tr>
<td></td>
<td>ISCAN</td>
<td>115</td>
</tr>
<tr>
<td>Selbourne house</td>
<td>Paediatric dietetics</td>
<td>43.5</td>
</tr>
<tr>
<td>Tameside general hospital</td>
<td>Orthoptic &amp; optometry</td>
<td>52</td>
</tr>
<tr>
<td>Various locations in the community</td>
<td>Health mentors</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Health visiting team</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>School nursing team</td>
<td>65</td>
</tr>
</tbody>
</table>

(Source: CHS Routine Provider Information Request – Referrals tab)

Learning from complaints and concerns
The directorate treated complaints and concerns seriously, investigated them and learned lessons from the results. Lessons learned were shared with staff.

In total, the whole directorate had two complaints from patients and relatives across its departments from December 2017 to November 2018.

There was a transparent and proactive complaints policy available for staff. Complaints leaflets were available within the departments and complaints could be made via the trust website.

Managers told us that complaints were dealt with proactively and, wherever possible, they would be dealt with internally by services and de-escalated. If patients or families wanted to escalate a complaint and were not happy with the way they were dealt with by the service they were referred to a formal complaint internally within the hospital. The quality and governance, patient advice and liaison service and complaints department, would then process the complaint. The trust target was to respond to complaints within 45 days.

If complaints were received, we were told they were shared with staff so that learning could be implemented.

Whist complaints were low, the directorate had a high number of compliments across all its departments.

From November 2017 to October 2018 there were 593 compliments across all departments.

**Summary of complaints**

From December 2017 to November 2018 the trust received two complaints in relation to community services for children, young people and families (0.5% of total complaints received by the trust).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

For the one complaint that had been closed at the time of data submission, the trust took 51.0 working days to investigate and close this. This is not in line with their complaints policy, which states complaints should be closed within 45 working days.

The one complaint that had not yet been closed had been open for 31.0 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From November 2017 to October 2018 there were 593 compliments received for community services for children, young people and families (4.4% of all received trust wide).

Compliments were received in all 12 months of the period. July 2018 was the month where the most compliments were received (76).
(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The directorate was led by a head of service, service leads and team leaders who managed all staff. We found managers had the right skills and abilities to run the directorate providing high-quality sustainable care to families and children.

The directorate had a strong and varied leadership team who had a wide breadth of experience in working with children. Whilst the directorate were part of a wider organisation, managers were obviously passionate about services provided in their specialist area.

Management backgrounds included professionals from different disciplines such as health visitors, school nurses and therapists. The managers backgrounds had a positive impact on the staff’s view of leadership. Staff felt managers had a vested interest in their roles and understood the complexities of differing job roles.

The head of service and senior managers updated staff on progress in the directorate and were clearly well known and visible in most sites. Staff told us they were kept up to date through direct feedback from managers in team meetings and one to ones.

We found a compassionate, inclusive and effective leadership team both at senior management and team management level. Staff we spoke with said that the directorate had good leadership who were available and present.

Every staff member we interviewed felt supported by their local managers and we observed good team working in all the departments we visited.

Whilst the directorate staff were extremely positive about managers the service was about to lose the head of service due to retirement. Staff told us that the trust had decided to integrate children’s community services with children services in the hospital under one management structure. The actual structure had not been agreed at the time of our inspection.

Managers were positive about the opportunities the future presented, but also felt strongly that community services should be seen as an equal partner in the new venture.

The staff felt the immediacy of hospital services could supersede the holistic nature of what they did. Treatment had to be delivered on the spot in hospitals, whilst community services worked with families over a long period of time, sometimes years.

It was clear that staff were nervous that hospital treatment would be prioritised by a new head of service, but they were clear that the input into families was just as important and the social and health cost savings were just as important.

In our inspection, we talked to the senior management team and they were aware of these concerns and wanted to ensure that the essence of what the director did was not lost in any structural change.

Vision and strategy

Tameside and Glossop commissioners, borough council and the trust, were working together to develop, introduce and operate an integrated system of health and social care in Tameside and Glossop.

The programme was called care together. The care together programme aims to develop a new kind of NHS provider organisation known as an integrated care organisation.
The programme will provide the foundation for one of the first integrated care organisations in England, bringing together a wide range of health and social care services for the benefit of local people.

The vision is that services will work collectively to manage a person’s entire care in a holistic manner.

Community health services for children, young people and families were part of this vision and in the near future it will start to develop integrated services with partners in Tameside.

The directorate had its own vision which was built on the belief that every child, young person and family in Tameside and Glossop matters. The directorate believed that every child and young person should be nurtured, safe, prosperous, skilled and healthy.

The directorates underpinning principles were based on the united nations convention on the rights of the child (1989) and applied to children’s services provided by the trust. The principles themselves focused on the rights of children and families to live in an environment that fosters growth and development.

**Culture**

Community health services for children, young people and families spoke with passion about their roles and felt supported by their colleagues and managers.

It was clear they felt the directorate had an ethos and culture of its own. Staff felt the culture within the children’s services had been excellent because of the background and understanding of the management team.

All the staff spoke positively about their local managers across all the services we visited. We found the senior management team to be visible, approachable and hands on in their management of the service with a good understanding of the staff concerns.

Staff felt supported and valued by their managers at every level and told us about managers being supportive of problems or anxieties either at an individual or team level.

The trust had a lone worker policy. Implementation of this varied by service, but primarily services required staff to ensure their appointment calendars were up-to-date and accurate and that staff rang the office to confirm when they had finished an appointment or completed their shift for the day.

**Governance**

We saw clinical governance committee meetings minutes and reports which took place quarterly to discuss risks, incidents and key issues.

Team directorates meetings structure included governance as an area of review and discussion for individual services staff and managers.

Performance information was prepared by the trust and shared with managers and individual teams so that action could be taken on performance areas or good practice shared.

We saw a governance log which highlighted all the actions from monthly senior management meetings. The log showed evidence of two years of meetings across the directorate including the
service line discussed and any issues which had arisen as part of the discussion. The log also had an action column which included the responsible person to manage any action or issue and a completion target and completion date.

Nearly all the targets had been completed or were in the process of completion.

Areas of the directorates performance and governance data were reviewed across the trust’s structures, so that all levels of management across the trust were fully informed of progress.

The directorate contributed to the hospitals quality report which set targets for compliance. The report included reporting on infection control measures, incidents across the hospital and time taken to review them and mandatory training, staffing and complaints.

The directorates services also provided Board reports so that the trust executives could review performance and learning.

**Management of risk, issues and performance**

Staff in all the services we visited told us that good governance structures were in place where staff meet and shared information and learning from alerts, incidents, risks, complaints and concerns.

The directorate provide us with a learning log which showed how the director shared learning across all its services.

The directorate held a risk register which we reviewed whilst on inspection. The register was current and had the risk mitigation and individuals responsible for actions as well as review dates. The risks matched those we saw on the directorate, had been reviewed and were low in nature.

**Information management**

The directorate collected, analysed, managed, shared or used information well to support all its activities.

We saw evidence that services collected performance measures and data which enabled the management to understand areas of improvement.

The data included patient questionnaires, audits and governance data which were shared with staff by managers and actioned. This demonstrated a commitment to sharing data and information proactively to drive and support decision making in the service as well as hospital-wide working and improvement.

Policies and procedures were readily available on the trusts intranet site and all staff told us that they had access to it.

**Engagement**

Staff told us that they had high levels of constructive engagement with managers and managers were visible to the staff and public. The engagement included newsletters with staff and feedback from patient questionnaires.

Newsletters for teams were shared across pathways on a quarterly basis for updates, news shared learning and congratulations.
At the time of our inspection many of the changes that were occurring in adult and hospital services had not occurred in the directorate. Staff and patients were aware that there were plans to integrate services but this was only at the preliminary stage.

We were told by managers that the directorate and the trust was working on an action plan which would introduce changes in its structure to align its services with hospital departments and other organisations in Tameside. The plan would be shared with staff and patients so that staff and communities could be engaged in any change that occurred.

Learning, continuous improvement and innovation

We saw a lesson learnt log from incidents log 2018-2019, which was continually shared and discussed with staff throughout the year.

The document was comprehensive and showed how the directorate learn from incidents by sharing incident information or developing new ways of working. The log showed what the incident was, where it occurred, lessons learnt and how the learning was shared.

Staff also shared incidents from regional or national incidents which they had acquired through their networks. We saw evidence of how learning from a local hospital was shared with staff health visiting staff from Tameside.

The directorate had developed a story-boards and patient stories showing good practice and learning from practice.
Community health services for end of life care

Facts and data about this service

Community health services for end of life care at the trust are provided by the palliative care team based at Crickets Lane Health Centre.

The trust provided the following information about community health services for end of life care at Tameside and Glossop Integrated Care NHS Foundation trust:

The community specialist end of life palliative care team sits within the division of intermediate tier services enabling effective communication and liaison with other services including integrated urgent care team, district nursing services, single point of contact and out of hours district nursing services.

An open referral system is in place allowing patients and families to refer as well as health practitioners. The service provides face to face assessment and support to patients experiencing issues with management of complex symptoms, such as psychological care and pain management.

Support provided may be on a short-term basis until symptoms are controlled or may be provided longer-term through to end of life. Staff within the team are linked to specific GP surgeries and attend relevant Gold Standard Framework (GSF) meetings to ensure holistic care provision to individuals. The team contains independent non-medical prescribers, supporting rapid access to symptom management and control.

The service includes a palliative care respite team that provides a sitting service and support to patients/carers, allowing them to take periods of rest between caring duties. Staff are employed to provide ‘night sits’ to those who may need it. The service coordinator coordinates the Marie Curie service to ensure equity across those requiring night sits. The team works closely with the DN service and provides elements of personal care to patients and second checks for syringe drivers, where required.

(Source: Universal Routine Provider Information Request (RPIR) – Sites tab / CHS Routine Provider Information Request (RPIR) – Context CHS tab)

End of life care services are part of the integrated model of care within the community setting. This model serves five neighbourhood teams: Denton, Audenshaw and Droylsden (DAD), Dukinfield, Mossley and Stalybridge (DMS), Ashton, Hyde and Glossop. All the services were inter-linked with each other and included integration from the social work department. All services were commissioned by Tameside Care Commissioning Group.

We spoke with district nursing teams based at Crickets Lane Health Centre, Ashton Primary Care Centre and Glossop Health Centre. We also visited a local hospice to observe a multidisciplinary meeting.

We visited three patients at end of life in their homes to observe care and looked at the patient
records that were held in their homes. We also spoke to two bereaved relatives over the telephone to ask how the care had been for their loved one.

We reviewed 10 patient records that included five active and five deceased.

The inspection was a short-announced inspection (staff knew we were coming shortly before the inspection) to ensure that everyone we needed to talk to was available. The service had not previously been inspected.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**
The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Each staff member had a personalised electronic dashboard to highlight to them when their training was due for renewal. Staff told us that they did not get protected time to complete this training and at times had to complete this in their own personal time.

Management were emailed monthly to demonstrate their teams’ compliance rates and the electronic dashboards were discussed as part of the appraisal and personal development process.

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing staff in community health services for end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 1</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community health services for end of life care the trust had an overall mandatory training compliance rate of 97.2% for qualified nursing staff. The 95% target was met for five of the six mandatory training modules for which qualified nursing staff were eligible.

It should be noted that the training module not meeting the target is due to only one eligible member of staff not having completed the training, so the performance should be taken in context when dealing with low numbers of eligible staff.

**Medical staff**
The trust did not report any medical staff working in community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

However, the trust had a locum palliative care consultant who had been in post for three weeks at the time of inspection. The consultant shared their time between the acute trust, the local hospice and the community service. We did not see evidence that they had completed their mandatory training courses, but we were told by senior managers that they were all planned into the consultant’s diary for completion.

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.

Staff we spoke to told us that if they had a safeguarding concern they would speak to their manager who was the safeguarding lead in the first instance. The lead nurse was a safeguarding adults’ manager (SAM) who made decisions, provided guidance and had oversight of any safeguarding concerns that were referred to the local authority.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust did not report making any safeguarding referrals concerning adults within community health services for end of life care for the period February 2018 to February 2019.

We observed templates to improve staff confidence in managing least restrictive and timely responses to safeguarding concerns, adults who lack capacity, and those who may require legal authorisation for deprivation of liberty. In addition to this we were told that the electronic management information system incorporated trigger safeguarding questions for safe identification of safeguarding concerns.

Managers told us that any safeguarding concerns would be shared in staff meetings. We saw evidence of this in the team meeting minutes that we reviewed.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for qualified nursing staff in community health services for end of life care is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community health services for end of life care the trust had an overall safeguarding training compliance rate of 100% for qualified nursing staff.

It should be noted that this data refers to only six eligible staff, so the performance should be taken in context when dealing with low numbers of eligible staff.

Medical staff

The trust did not report any medical staff working in community health services for end of life care.

*Source: Universal Routine Provider Information Request (RPIR) – Training tab*

See comments above under medical staffing.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well and staff kept themselves and the equipment used clean. Staff we spoke to were aware of their roles and responsibilities. We observed there was an infection control policy in place which was available via the trust intranet.

We saw that all palliative care staff had completed the infection control module of their mandatory training.

Staff undertaking community visits had adequate supplies of hand gel sanitiser and personal protective equipment which included sharps boxes.

We reviewed monthly hand hygiene audits and figures demonstrated 100% compliance. We also observed community nurses washing their hands following care interventions in all areas. This practice adhered to the National Institute for Health and Care Excellence (NICE) Quality Standard (QS61:3) in which people receiving healthcare from healthcare workers decontaminate their hands immediately before and after every episode of direct contact or care.

Staff told us that they had received training in aseptic techniques, however we did not see documented evidence to support this. We raised this with management and were told that staff had received the training and the team leader was in the process of developing a structured training plan so that all training could be monitored and documented as completed. We observed care plans to be used for people who required urinary catheters. These adhered to the National Institute for Health and Care Excellence (NICE) Quality Standard (QS61:4) so that the risk of infection was minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

We reviewed a standard operating procedure on syringe drivers which encompassed instructions on the decontamination process of the equipment. In addition to this, we observed boxes with lid covers that the syringe drivers were kept in and these had ‘I am clean’ stickers on them once decontaminated. We also saw that the equipment that needed cleaning was stored separately from the clean boxes. The documentation on the cleaning process was clear and concise, signed...
and dated. We randomly chose a syringe driver box and observed that it was visibly clean, service in date and all contents required were in place.

We were shown the alert system on the electronic management information system. This alerted staff to any infection concerns.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

One brand of syringe driver was used within the community setting which ensured a consistent approach to the care of patients requiring a subcutaneous infusion.

We observed two syringe driver care plans and checklists. Both included the name of the drug, the date it was prescribed, the dose, the volume of infusion and infusion rate, the position of the cannula and its change of position, hourly checks signed and dated and battery life and if changed. Both sets of documentation were clear, legible, concise and completed fully.

Safety checks on the syringe drivers were carried out by the palliative care respite team before they went out to patients. On return they were cleaned by the palliative care respite team in line with the standard operating procedure and the trust’s infection control policy.

Equipment that may be required in the patient’s home was organised by the district nursing team. Equipment was ordered from an external party, before 4pm by the district nurses and after 4pm by the out of hours service. Equipment could be supplied seven days a week, 24-hours a day.

Fire exits were clearly signposted in the health centres. Fire break glass points were observed at each exit that complied with BS EN 54-11 and review of the fire extinguishers within Crickets lane health centre were in date with their annual service.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. Records demonstrated that a range of risk assessments were undertaken for patients at the end of life. We observed risk assessments for pressure ulcers, malnutrition universal screening tools and slips, trips and falls that were regularly reviewed where appropriate.

Each service in all five neighbourhoods held morning safety huddles. Discussions took place on caseloads, staffing, incidents and any safeguarding concerns. In addition to this, lone working was discussed, and joint visits carried out if required.

Referrals were received by phone, email or letter and could come from a range of sources, such as hospitals, GP’s, district nurses, specialist nurses, patients or relatives. All referrals were triaged by the single point of contact (SPOC) team and categorised by need and risk.

There was a co-ordinated approach within the community palliative care teams if additional advice and support was needed, particularly around symptom control. Nursing staff could contact the consultant at the local hospice for advice.

At a multidisciplinary meeting we attended, we heard discussions on risk issues, for example the administration of controlled drugs in patient homes and the deterioration of patients. Actions to assess and mitigate the risks were identified.

Patients were cared for in their preferred place of care where possible. Where a patient deteriorated, appropriate transfer was made either to the local hospice or the trust.
Staffing

The trust reported the following qualified nursing staff numbers for the two periods below for community health services for end of life care:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>7.4</td>
<td>7.4</td>
</tr>
</tbody>
</table>

The trust reported a qualified nursing staffing level of 100% in community health services for end of life care from April 2017 to March 2018 and from April to November 2018. The WTE staff in post and the WTE staff planned for remained the same between the two-time periods.

(Source: Universal Routine Provider Information Request (RPIR) – Total Staffing tab)

We were told by managers that safe staffing levels were always maintained. Staffing was reviewed daily and if capacity was an issue management could call on other teams for support. An acuity tool was not used for staffing as management felt that it was not required. Staff told us that their caseloads were manageable and if a staff member was to phone in sick the workload would be shared within the team.

Staff told us that a business case had been sent to the trust board to expand the palliative care respite team as their referrals were expediting. However, post-inspection the trust told us this had been discussed at the end of life programme board and an alternative course of action had been agreed across the local health economy.

We spoke to the end of life care facilitator who at the time of inspection was drafting a business case for more support as she was providing support and training to GP’s, care homes, district nurses, palliative care nurses, palliative care respite teams and other teams that were under the intermediate care services by herself.

Vacancies

The trust set a target of 4% for vacancy rate.

From December 2017 to November 2018, the trust reported an overall vacancy rate of 0.9% for qualified nursing staff in community health services for end of life care. This was lower than the trust target of 4%.

(Source: Universal Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover

The trust set a target of 12% for turnover rate.
From November 2017 to October 2018, the trust reported a turnover rate of 13.7% for qualified nursing staff in community health services for end of life care. This was higher than the trust target of 12%.

(Source: Universal Routine Provider Information Request (RPIR) – Turnover tab)

Sickness

The trust set a target of 4.2% for sickness rates.

From November 2017 to October 2018, the trust reported a sickness rate of 0.0% for qualified nursing staff in community health services for end of life care. This was lower than the trust target of 4.2%.

(Source: Universal Routine Provider Information Request (RPIR) – Sickness tab)

Nursing – Bank and Agency Qualified and Non-Qualified nurses

The trust did not report any bank or agency usage for qualified or un-qualified nurses in community health services for end of life care from November 2017 to October 2018.

(Source: Universal Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

Medical locums

The trust did not report any medical locum usage in community health services for end of life care from November 2017 to October 2018.

(Source: Universal Routine Provider Information Request (RPIR) – Medical Locum Agency tab)

A locum palliative care consultant had recently been employed by the trust. We were told by senior management that they had been struggling to recruit to this post and this was mirrored nationally with a shortage of staff within the palliative care setting.

Suspensions and supervisions

During the reporting period from December 2017 to November 2018, the trust did not report any cases where staff have been either suspended or placed under supervision in community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)
Quality of records

Staff kept detailed records of patients’ care and treatment. The service used both electronic and paper records and the trusts’ vision and strategy was to become paperless. We reviewed the trust’s records policy which was version controlled and in date.

We looked at 10 patient records, five active and five deceased. The sample of records looked at combined cancer and non-cancer patients. All the records were clear, legible, signed, timed and dated. Patient details were documented on each sheet of paper, however three of the records did not have the patient’s National Health Service (NHS) number documented.

Staff told us that patient consent was obtained for shared access at the first initial appointment. We noted that in all 10 patient records a consent to care and a preferred place of care was documented and achieved. In addition to this we noted that the initial holistic nursing assessment was completed, and medications documented. However, we did note that all records we reviewed did not have a spiritual needs assessment completed. The National Institute of Health and Care Excellence (NICE) Quality Standard 13 states that spirituality is an important aspect of holistic care and service providers should ensure that systems are in place to offer, facilitate and provide (including sign-posting and referral) spiritual and religious support to people approaching end of life that is appropriate to the person’s needs and preferences.

We observed that patients had a plan of care which provided information about their medical, physical, emotional and social aspects of care. Specific wishes were recorded in advance care plans (ACPs) and statements of intent. We saw a copy of the new advance care plan which demonstrated that there was a process of discussion between the patient and their care provider, for example, what was most important to them regarding their care and wellbeing, what brought the patient comfort and helped them cope and had they made a will or made funeral plans.

We also saw a copy of an advance care plan for those who lack the mental capacity to make these decisions and we noted that the information recorded on the form was only to be used as part of a best interest decision making process at such a time when a decision needed to be made.

A frailty screening tool was evident in all the patient records we reviewed, this had a scoring system in place and scores above three would prompt action needed. However, a frailty score above three did not mean that a patient was automatically entitled to receive continuing health care funding. This tool was being monitored and compared with the check list for continuing health care funding over the next few weeks following the inspection to ensure that the tool was appropriate for the use with end of life care and long-term condition patients. All notes were stored securely in a locked cabinet.

Verification of death could be completed by either a doctor or a clinical nurse specialist who had received the training. We reviewed four verification of death documents, two were verified by a clinical nurse specialist and two by a GP. All forms were fully completed, legible, dated and signed. Managers told us in the Glossop neighbourhood that a clinical nurse specialist could verify a patient’s death, but this would need a counter-signature by a GP. This was due to patients residing in the Derbyshire area and not Tameside.

We carried out a home visit with a district nurse and a physiotherapist from the integrated urgent care team. On review of the patient’s documentation, the district nurses care plans had minimal information on them for monitoring the patient’s symptoms, pain control, diet and fluid intake. However, there was a malnutrition universal screening tool (MUST) document in place but again this was partially completed. There was no evidence of a full nursing assessment.
We observed on the service risk register that managers had highlighted there was a risk of nursing records being lost or tampered with in the patient homes. The trust was rolling out a paper lite information technology system within the electronic information management system. This would remove the need for paper records in people’s homes. Staff told us that they had been involved in this project by suggesting what information should be left in or taken out.

We also saw that the service had identified that there was a risk that nursing records could become damaged or lost whilst being transported between the office and the patients home address. This could result in lost or damaged records, a break in continuity of documentation as well as a breach of confidentiality of the patient. We saw that there was a trust policy on the transfer of patients notes and these were to be transported on an essential basis only. We spoke to staff on this subject and were told that the service used carbon copy documentation; the top copy would be taken back to the office for storage in the patients notes and the carbon copy would remain in the patient’s home. All care plans remained in the patient’s home address.

Management told us that the electronic templates in the electronic management information system were based on the carbon copy documentation. We reviewed this system and staff told us that becoming paper lite would be a much easier process with mirroring some templates. In addition to this, staff told us if the information technology system went down then the paper copies would still be ideal to use.

Record keeping audits were completed quarterly. We reviewed an audit for the period October to December 2018 and saw that results demonstrated there was no National Health Service (NHS) number on each page and no Nursing and Midwifery Council (NMC) registration number documented. An action plan had been implemented and a pre-printed signing sheet was inserted into all patient notes so that all signatures and names were recorded.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. We reviewed five prescription charts that were in patients’ records and all had end of life medicines prescribed for regular administration.

End of life medications were administered in accordance with prescription and anticipatory guidance from the National Institute of Health and Care Excellence (NICE) Quality Statement Three: Anticipatory prescribing. We noted in the 10 patient records we reviewed that an authorisation to administer controlled drugs document was in place and recorded. All prescriptions were legible, signed, timed and dated.

We were told by staff in the integrated urgent care team (IUCT) that anticipatory drugs for patients on rapid discharge from the trust were completed by the ward doctors before discharge. GP’s would prescribe the medications once the patient was in the community setting. We did not inspect acute end of life care at the time of inspection.

We reviewed guidance on the use of anticipatory medications in the last days of life published by the palliative care team and the acute trust. This had been cascaded to all registered nurses in the community services via team talks and emails. The guidance gave an example of a patient deteriorating with chronic obstructive pulmonary disease and the medications that were prescribed. Staff told us that having an example included within the guideline had been extremely helpful in helping with their anticipatory prescribing of medications.

There were four non-medical prescribers in the end of life care team and one member of the team was awaiting a start date to commence the non-medical prescribing course. The trust had a non-
medical prescribing lead and there were regular forums and updates for the non-medical prescribers.

The prescription pads (V300) were kept in a locked cupboard in the office. Staff told us that when out on visits the prescription pads were kept in the boot of their cars and taken out at night and stored in their own homes if they were not able to get back to the office. This complied with the trust’s non-medical prescribing policy.

There were no patient group directives within the service. If a patient required two litres of oxygen for support, then this had to be prescribed by a doctor or a non-medical prescriber.

Staff told us that medicines would be checked at each patient visit. Any missing medications would be incident reported and reported to their line manager as per the trust medicines policy. If there was an issue with drug abuse in the patient’s home staff told us a safe would then be installed in their home and access only given to the healthcare professional providing care at that time.

We were told by staff that if medicines were required out of hours then these would be available either from the local hospice or out of hours GP’s. There was a system in place for these events if they were to occur.

There was a neighbourhood pharmacy team that the staff in the service could access when required. The pharmacy team provided support to the end of life care team and supported vulnerable patients with their medications.

The palliative care respite team provided a second signature for syringe drivers in the patients’ homes. Controlled drugs were disposed of as per trust policy.

We reviewed the trust’s medicines policy, version 3.32, review date March 2019. Managers told us that the policy was out for approval at the time of inspection and the new version would be clearer for staff working in community services. We also reviewed the trust’s non-medical prescribing policy, version one and saw that this was in date and for review in January 2022.

**Incident reporting, learning and improvement**

The service knew how to manage patient safety incidents. Staff told us that they would recognise incidents and would know how to report them confidently to their manager and via the trust electronic management system.

We were told by managers that there had been no incidents, both clinical and non-clinical during the period February 2018 to February 2019. We were also told that if an incident was to occur these would be investigated, and lessons learnt would be shared with the team by team meetings and emails.

We observed during the multidisciplinary meeting at the local hospice that concerns were shared on a public health issue warning that they had received from external stakeholders on the use of a non-opioid drug. Discussions were held on the symptoms that a person would present with if they had been taking this drug.

**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.
From December 2017 to November 2018, the trust reported no incidents classified as never events for community health services for end of life care.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for end of life care, which met the reporting criteria, set by NHS England from December 2017 to November 2018.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents (SIRI) – Trust data**

From December 2017 to November 2018, trust staff within community health services for end of life care reported no serious incidents.

This is comparable with that reported to Strategic Executive Information System (STEIS) data. This gives us more confidence in the validity of the data.

(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)

**Prevention of Future Death Reports**

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports relating to community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)
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 service benchmarked themselves with other external providers to ensure best practice was always maintained.

The trust used numerous guidelines such as the National Institute for Health and Care Excellence (NICE): End of Life Care for Adults (Quality Standard 13); Care of Dying Adults in the last days of life (NICE guidance 31) and Strong opioids for pain relief (NICE CG140).

The care provided by the service was based on the Gold Standard Framework (2012). The framework was a model of good practice that enabled a ‘gold standard’ of care for all people who were nearing the end of their lives.

Integrated co-ordinated care took place with weekly multidisciplinary meetings, populating gold standard framework registers and pro-actively supporting gold standard framework meetings in all neighbourhoods.

Staff in the Glossop neighbourhood used the trust’s 100-day challenge to identify 1% of the registered population of Glossop, which staff said should be on the gold standard framework register. Staff told us that this group of patients should be supported as early as they are identified, rather than just at the end of their life. Staff showed us an example of an electronic gold standard framework register which was being rolled out in their district so that all GP practices were aligned to it.

The electronic gold standard register ensured continuity of care and ensured that no patient was missed off the register. All patients were red, amber and green (RAG) rated so that the healthcare professionals in the gold standard framework meetings could better plan the patient’s needs and improve outcomes for those living and dying in the place and manner of their choice. Funding for this new initiative was from an external party.

Following involvement with the ‘North West Audit Group’ in 2017, the service had implemented an ‘Individual Plan of Care’ (IPOC) document. This care plan replaced the ‘Liverpool Care Pathway’ and was used to record the individualised care delivered to the dying person in the last days and hours of their lives and supported their families, carers and those close to them.

We observed this document in the patient records we reviewed and observed that there was an initial medical and nursing review regarding the diagnosis of dying; an initial medical and nursing communication with the dying person and those important to them; an initial multidisciplinary team assessment, plan of care and review; an evaluation of the plan of care and support and a record of care and after death.

This document was being used in the Tameside area, however staff in the Glossop neighbourhood told us that although GP’s in the Hollingworth area used the form, GP’s in the Glossop area were reluctant to use it as they felt it was a step back in time as they were continually repeating themselves. The nursing staff disagreed with this as the form housed all the documentation required on one form. Whilst the form was not endorsed by the National Institute of Health and Care Excellence (NICE) it is best practice to use it. Managers told us that they were holding regular meetings with GP’s to try and get them on board, but this was work-in-progress at the time of the inspection. At the present time nurses were continuing to use individual care plans and GP notes on the electronic system for documenting the patients care at end of life.
We saw action plans in place for the palliative and end of life care programme which considered guidance from the 'Ambitions for palliative and end of life care: a national framework for local action 2015-2020 and the ‘Ambitions Framework: Greater Manchester Palliative and End of Life Care’ discussion paper which outlined requirements in the Greater Manchester Cancer Plan.

The service followed the Priorities for Care of the Dying Person. These are laid out in the 'One Chance to Get It Right Report' which was developed by the Leadership Alliance for Care of Dying People (LACDP). Staff have a responsibility to follow these priorities and the staff we spoke to told us that it was 'linked in' with their end of life care training and the principles put into practice.

**Nutrition and hydration (only include if specific evidence)**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff we spoke to knew the importance of the malnutrition universal screen tool (MUST). We saw evidence of the use of this tool in the patient records we reviewed. Food and drink were assessed as part of the clinical assessment process and recorded for each patient.

Nausea and vomiting were discussed as part of the assessment and triage process for patients who were unable to eat and drink. Referrals could be made to the dieticians if required following this assessment.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. However, we were told by staff that they did not routinely use a validated pain tool but relied on facial and verbal expressions. In addition to this, we were told that staff did not routinely use a cognitive impairment assessment tool for those patients with cognitive impairment, but again relied on verbal expressions.

We reviewed 10 patient records and pain assessment was recorded by non-verbal communication, for example, one records documentation stated, “patient gripped nurses’ hand to indicate no pain” and another recorded “patient groaned”. The decisions to not use a recognised pain assessment tool within the palliative care setting were not following best practice as identified in the core standards for pain management services in the UK.

We reviewed the palliative pain and symptom control guidelines policy, version four and this was for review in February 2018. We raised this with management and was told that a new policy was in progress, however nothing had changed since the policy was implemented and therefore no changes were required. Managers told us that they were waiting to get a palliative care consultant for input to the new policy.

We were told by staff that they would use the World Health Organisations (WHO) analgesic ladder for prescribing pain relief medications. We reviewed a leaflet on strong opioids (painkillers) in cancer and palliative care that was available for patients and their families. This leaflet was based on guidance from a variety of resources such as the National Institute for Health and Care Excellence (NICE), the British Pain Society and Macmillan. Staff in the trust and the community setting could access advice from the specialist palliative care team if required 24 hours a day.

We saw on a home visit that for pain and symptom control, prescriptions were in line with the National Institute for Health and Care Excellence (NICE) guidance CG140 and NG31.
Patient outcomes

The trust has not participated in any clinical audits in relation to community health services for end of life care as part of their Clinical Audit Programme.

(Source: Universal Routine Provider Information Request (RPIR) – Audits tab)

Gold Standard Framework meetings ensured that an evidence-based approach to optimising care for all patients approaching end of life would be achieved. The new electronic register that was being rolled out in the Glossop district would ensure that all records, discussions, decisions and outcomes were in a similar format. This would also ensure that data captured could be audited and improvements made if needed.

We reviewed an audit completed on audit standards in the last two weeks of life. This looked at numerous items, such as recognising the dying patient, communication, goals of care, priorities and wishes for care and involvement of the patient. Results demonstrated that documentation of a holistic assessment after recognition of the dying phase and care planning of the patient’s spiritual needs was not always evident. We spoke to the end of life facilitator about this and were told that refresher training was being planned for staff to action this outcome. No date had been set at the time of inspection, but we saw an action plan with a timeframe for this to be achieved.

Achievement of end of life palliative care patients dying in their preferred place of care (PPC) was monitored monthly. We reviewed the data which showed that for the period February 2019, 89.5% of patients achieved their preferred place of care. However, due to the small sample size the district nursing service were going to capture this data as they cared for a significant proportion of patients dying at home. This would allow a greater understanding of achievement of PPC and to consider the reasons why if this was not achieved.

We were shown audit figures of PPC from the head of patient flow in the trust in relation to fast track referrals. For February 2019, 72% of the 13 referrals achieved PPC, four of the patients were too ill to move.

The individualised plan of care (IPOC) usage was monitored monthly. We reviewed the audit for February 2019 and figures showed that only two out of the 12 forms had been fully completed. Forms were often incomplete or not used at all. We were told by management that more work was to be done to improve this outcome. An electronic template within the electronic management information system had now been implemented and the plan was for each team to have ownership of compliance. A multi-professional task and finish group was also being convened to conduct a further review of the IPOC document. This would then be presented for feedback to the Partnership Engagement Network and to the Local Medical Council (LMC) before bringing this back to the Health and Care Advisory Group for sign off. The actions were incorporated into the End of Life Care Action Plan.

We reviewed an audit which had been completed for February 2019 on anticipatory medications being prescribed and administered. Figures demonstrated 100% compliance and the audit also demonstrated that there was evidence of discussion between the patient and their family and that recognition of dying was clearly recorded and identified in all cases.

The service had carried out their own care of the dying audit in January 2018 as the national audit was not due until later this year. This audit was based on 55 forms and reviewed the completion of patient notes, figures demonstrated that 81.8% of the patients’ notes had completed section two which detailed additional information and not just expected death, of this percentage, 54.5% had additional details added, for example Gold Standard Framework stage. Management told us that
86% of the forms had been sent via an nhs.net account which demonstrated good governance, however 4% (which equated to two records) had not been sent via this method and were therefore not encrypted. This was followed up and an action plan put in place.

We were told by managers that an audit was in progress on the use of the special patient note, including the statement of intent. A special patient note was implemented by the end of life care facilitator which enabled GP’s to describe information about patients with complex health and social needs. This audit would be commenced post-inspection. Management also told us that they currently received public health data and that a task and finish group were developing a dashboard to focus on wider key performance indicators and not just ‘death’ in the usual place of residence. This information would benefit the service in improving outcomes for their geographical population.

The service was not capturing or auditing non-cancer patients and black and minority ethnic groups. Managers said that this would be part of their audit programme going forward.

We were told by management that the implementation of the digital health service based at the trust had reduced hospital admissions within end of life care, however we saw no documented evidence to corroborate this and were told that they were in the process of auditing the figures.

**Competent staff**

The service made sure staff were competent for their roles. All new staff were given a supernumerary period. Induction packs were given to all new staff including a competency checklist with a list of items that had to be completed. We reviewed a new staff members folder and noted reviews and action plans for achievement.

Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. In addition to this, we were told by management and staff that external clinical supervision was provided which was mandatory for staff to attend, this allowed the opportunity for case review and debrief as required.

The trust provided the following information about their clinical supervision process:

- Junior doctors access supervision via a nominated consultant (included on the GMC register of accreditation) and the organisation manages a live database. Consultants access clinical Supervision via their clinical director.
- Nurses undertake clinical supervision in preparation for or as an outcome via revalidation, where they reflect on their practice with a clinical supervisor followed up regularly with one to one meetings.
- Formal supervision is provided to newly qualified nurses via preceptorship including informal monthly meetings/formal discussions at three, six and 12 months post registration. Following any serious event, it would be normal practice for a debrief with teams effected to occur and be led by the most appropriate professional. Counselling services are also available for staff as required.
- Allied health professional clinical supervision includes all staff band seven and above having a one to one every month as appropriate. On a six-weekly basis staff in bands five and six undertake joint working such as accompanied visits; reviewing notes to facilitate discharge from a caseload; joint completion of a root cause analysis, joint review of a complaint; reflective practice of an issue with their clinical supervisor.
In our safeguarding supervision policy frequency and method is dependent on role and responsibility and compliance is assured via safeguarding performance dashboards.

Any issues would be reported by exception to the medical director, chief nurse or director of human resources and organisational development via educational governance group, workforce committee (which is a sub-committee of the board), nursing leadership forum.

(Source: CHS Routine Provider Information Request (RPIR) – Clin Supervision tab)

From February 2018 to February 2019, 100% of all required staff in community health services for end of life care received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>February 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>7</td>
</tr>
<tr>
<td>Support to doctors and nursing Staff</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

We were told by managers and staff that there was no competency framework for new nurses into the specialist role and this was an area that the end of life care facilitator was developing. However, we were told that palliative care nurses required level three training in palliative care; if they did not have this on recruitment to the post they had a set timeframe to achieve it.

Syringe driver training was provided internally with competency assessments. The training was carried out annually, but staff could access training as required.

All staff within the service, both qualified and non-qualified had completed a communication module which provided structure for conversations, based on the evidence behind effective communication. Staff we spoke to were proud that the administration staff completed this module as they were usually the first point of contact for the patient and their families.

The palliative clinical nurse specialists had completed a palliative care module at Masters level and development opportunities were available for staff who had not yet commenced it. All clinical nurse specialists had advanced clinical skills which they had completed at Masters level.

Staff in the palliative care respite team received training sessions monthly. Staff had a workbook to collect evidence to demonstrate that they were competent for the role. We saw evidence of this workbook and noted action plans and timeframes for achievement. Staff told us that there was no protected time for training and that these sessions were usually completed in their own time. However, managers in the Glossop neighbourhood told us that they allocated protected time for their staff.

We saw a 12-month training plan for the period January 2019 to November 2019 for the end of life care facilitator to deliver in care homes. This encompassed training in subjects such as foundations in palliative care, recognising dying and end of life care and sage and thyme
communications. In addition to this we saw a 12-month plan for the six steps to care for managers of the care homes.

All staff had completed the ‘Daisy Accreditation’ training for dignity in care. This award-winning accreditation scheme was developed to be a quality marker for organisations to enable them to demonstrate that they have met the Daisy Standards. It is also designed to complement the already excellent levels of care delivered and to ensure that high standards and good practice are celebrated, recognised and shared. We observed the Daisy Mark plaque and staff dignity champion badges which were proudly displayed.

We were told by staff that snap shot training sessions on various subjects were utilised within the team meetings. This was welcomed by the team as they all stated that sometimes a quick re-cap on certain items within end of life care was needed. In addition to this, staff told us because there was no protected time set aside for training these sessions were invaluable. We brought this up with the end of life care facilitator and was told that attendance to training sessions was always poor due to no protected time given and due to capacity, it could not be improved at this time.

We spoke to the end of life care facilitator and management in relation to bereavement training and were told that this was not being carried out due to capacity and workload. Staff told us that this was an area that was not covered well, however staff did receive Sage and Thyme training to help with this part of the grieving process.

We saw student notice boards within the service which displayed a list of suggestions on areas that the students could visit for their learning, such as the integrated urgent care team, the extensive team and single point of access team plus information on any concerns relating to clinical placements.

There was a database on nursing registration and revalidation. Emails were sent out to highlight when a staff member was due for renewal. We saw that all qualified staff were in date with their registrations and revalidations.

We were told by management that due to the way that training was provided through the specific forums and bespoke training packages in the community and the trust, there was currently no central database that captured all the training delivered. Mandatory training was captured centrally and the trust was reviewing its process for the capturing of all training going forward.

**Multidisciplinary working and coordinated care pathways**

There was a co-ordinated approach to ensure patients received good care at the end of life. This was evident in the multidisciplinary meetings that we attended.

The locum palliative care consultant provided in reach and outreach services between the hospitals and community services as well as domiciliary visits to patients’ homes if required. A consultant from a local hospice and the GP Macmillan Lead could be also accessed by staff for advice if required.

The service all worked well together as a team. Joint visits to patients were arranged with various healthcare professionals if required and staff told us that these were invaluable for not only the patient but for integration of the community services.
Staff told us that being based in the same premises as the extensive care team (previously known as the long-term conditions team) had been extremely helpful in providing gold standard care. We were told that working with this team had ensured that fast track patients had been dealt with more efficiently and effectively and that continuing health care had improved. In addition to this, staff told us that collaborative working in frailty services had ensured that patients remained in their homes or in their preferred place of care.

The service had collaborative and integrated working with other services such as the integrated urgent care team, single point of access team and the speech and language therapy team. This ensured that the best quality and service was given to the patient and their family. Staff told us that integrating all the teams under one service had been invaluable to the service.

We spoke to members of the palliative care respite team; the aim of their service was to provide support to patients and carers in their home. This helped to reduce the chance of carer breakdown by providing respite from caring responsibilities. In addition to this, the respite team supported the district nursing team to provide palliation and personal care to patients.

Palliative care multidisciplinary meetings took place at the local hospice every Thursday morning. These meetings were attended by various healthcare professionals such as palliative care consultants, palliative care nurses, occupational therapists, physiotherapists and family support officers. Discussions took place on various items, such as palliative care nursing referrals, symptom management, discharge information and packages of care, all of which incorporated cancer and non-cancer patients. During the meeting we noted that there was no administration support and minutes of the meeting were not being documented. We raised this with senior management and following the inspection administration support was arranged for future meetings by the multidisciplinary coordinator in the extensive care team.

Multidisciplinary meetings were held every Tuesday in the Glossop neighbourhood, a variety of healthcare professionals attended, such as district nurses, paramedics, mental health, dementia service, palliative care nurses and GP’s had allotted times to ring in if they could not attend.

We saw evidence of monthly team meetings in the palliative care team which showed a structured agenda with staff initials and dates for actions to be completed.

We were told by staff that they had strong connections with other healthcare professionals in other services, such as the Parkinson’s specialist nurse, heart failure teams, chronic obstructive pulmonary disorder teams and acute management teams. This had a positive impact on the patients care pathway and ultimately saved on hospital admissions.

We saw evidence of good integration and communication with the local ambulance service. For example, the community paramedic in the Glossop neighbourhood had worked with the district nursing team in implementing an end of life care plan for the ambulance service. This was an example of good collaborative working which provided care to patients and their families.

The service was part of the Greater Manchester Strategic Clinical Network with their aim to improve quality, health outcomes and address unacceptable variations in health and care services. This enabled staff to understand the health needs of the local population and ensure consistency of care given to end of life care patients and their families.

Staff and managers attended regional and neighbourhood forums. We saw evidence of staff attendance at a regional forum in which the use of subcutaneous fluids in the community was discussed. Staff told us that these meetings provided updates on clinical practice and networking with other healthcare professionals.
The service had dementia champions, learning and disability link nurses and end of life champions in the community setting who met as a group each month. We did not see evidence of these meetings at the time of inspection.

Staff in the Glossop neighbourhood had good links and worked well with the specialist podiatrist. Staff told us that they could refer verbally to this service and the patients would be seen in a timely manner. The verbal referral would be followed up with an electronic referral to ensure an audit trail was documented.

We observed there was a strong relationship with all the neighbourhood teams under the intermediate tier service which demonstrated good collaborative working. All the teams we spoke to emphasised the importance of working together to improve quality and trust with a patient focus. For example, we observed multidisciplinary working that included healthcare professionals from a variety of backgrounds discussing patient pathways; this was a good way of sharing information more quickly than by routine electronic channels. This also avoided duplication as co-ordination of the right specialities was at the forefront of the whole division.

**Seven-day services**

End of life care services were based at Crickets Lane Health Centre and provided a seven-day service, 24 hours a day, seven days a week. There was a 24-hour advice line available via the local hospice.

The service had a dedicated phone number called the complex phone line. This was answered during the day by the single point of contact team and at night by the out of hours team.

The palliative care respite team provided a seven-day service from 8.30am to 5pm and 10pm to 7am. The team also offered a seven day/night sitting service.

The Integrated Urgent Care Team provided a seven-day service from 8am to 10pm.

Digital Health provided support from 7am to 10pm seven days a week. This service provided support to 45 out of the 46 care and nursing homes in the Tameside and Glossop area. The remaining care home was waiting to upgrade their Wi-Fi, so they could access the service. This service was available trust-wide.

The hospital chaplaincy service provided a multi-faith service 24 hours a day, seven days a week.

**Health promotion**

Records demonstrated that staff empowered patients to be as independent as possible. We saw documented evidence of staff signposting patients to other agencies for example, complimentary therapy at the local hospice, mindfulness classes and cancer rehabilitation services.

The trust had been chosen as the Greater Manchester site for a new screening project for patients who were at a high risk of developing lung cancer, for example smokers under 40 years old with symptoms.

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to told us they would contact the patients GP if they had any concerns. If the staffs’ concerns needed to be acted on at the point of contact then they would
contact their line manager, if not available the duty manager at the trust. Failing this they would contact the mental health team via the trust switchboard or alternatively dial 999 for emergency support.

All staff in the service had completed training on the Mental Capacity Act and the Deprivation of Liberty Safeguards as part of their safeguarding training. Staff told us that being integrated with social care had provided support to staff when they had concerns in relation to the Mental Capacity Act.

The trust set a target of 80% for completion of mental capacity act training.

From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 81.8% of eligible qualified nursing staff in community health services for end of life care compared to the trust target of 80%. It should be noted that the data for qualified nursing staff refers to 11 eligible staff, and so the performance should be taken in context when dealing with low numbers of eligible staff.

The trust did not provide data for any other staff group working in community health services for end of life care.

(Source: Universal Routine Provider Information Request - Training tab)

Managers told us that best interest meetings were organised with the mental health and learning disability teams as well as any other relevant healthcare professional.

Mental health support workers supported the specialist palliative nurses and the district nurses with patients suffering from dementia. Staff told us that this was good collaborative working in an area that was not their speciality. The trust provided a “Dementia Awareness” course, which was a 3-hour classroom-based teaching session delivered by the Dementia Admiral Nurse Service. Both clinical and non-clinical staff were invited to attend these sessions.

We were told by management that a specialist nurse for autism was coming to visit the community team’s post-inspection to carry out training on this subject. Staff told us that they did not see many patients in the end of life care service with this condition, but it was an area they were not familiar with and were completing the training.

Consent was gained from the patients and their families on every patient visit. We saw evidence of this in the patient records we reviewed, and we observed consent being taken at the home visits.

Seven out of the 10 patient records that we reviewed had a do not attempt cardiopulmonary resuscitation in place (DNACPR). We were told by management that the trust was moving towards the use of a recommended summary plan for emergency care and treatment (RESPECT) but this was work-in-progress.
Compassionate care

Staff cared for patients with compassion. We observed thank you cards and personalised letters from patients confirming that staff treated them well and with kindness. An example taken from a card stated “I need to say my heartfelt thank you, you made it possible for mum to be at home which is what she wanted. Your help has been immeasurable. Thank goodness for angels like you”. Another card read “Your compassion has helped us greatly”.

The friends and family test were not used in end of life care as managers told us the wording was not appropriate. The service used an adapted questionnaire which was more personalised to capture feedback. This was sent out on a quarterly basis. We observed feedback collated in February 2019 and 93% of patients were extremely likely to recommend the end of life care team. We also observed that 100% of patients were extremely likely to recommend the palliative care respite team.

We visited patients’ homes, observed care and spoke with patients and their families who spoke highly of the specialist palliative care team and the district nursing teams. We also saw that privacy and dignity was maintained during patient interactions.

We observed a certificate of good practice awarded to a member of the palliative care respite team for excellent working with the local hospice. This had been awarded as the team member had ensured that a patient in the last days of life had their wish granted, and this was to have a nice soak in the bath. This was achieved through teamwork and perseverance of the team member.

We attended a home visit with a district nurse and a physiotherapist from the integrated urgent care team. We observed good cohesive working and communication to the patient and their family from both healthcare professionals.

We were given numerous examples of compassionate care where staff had gone the extra mile and demonstrated person centred care.

Staff in the integrated and urgent care team told us about a patient who was being admitted to the local hospice and had requested to attend his wife’s grave before he went. The staff arranged with their internal transport service to take a detour to the cemetery so that his wish was granted.

Further examples were given; staff showed compassion to an end of life care patient and their ill spouse to ensure that they were both cared for at home. A social care package was co-ordinated and delivered within a few hours to ensure the couple were cared for in their preferred place of care. Staff told us they had one chance to get it right and they were proud that they did. A patient in their last days of life and had expressed a wish to be married. A staff member had then attended the patient’s home on their day off to do their hair so that the patient felt truly special on their wedding day. A staff member who had sat with a palliative patient’s daughter as they were unable to attend their mother’s funeral. At the exact time of the funeral they lit a candle together. This not only involved the patients relative, but it helped keep them calm on what was a very emotional day. The final example was of a patient who was at the end of life stage that had a parrot that the staff fed daily whilst caring for them. When the patient passed away the staff member adopted the parrot.

We spoke with two bereaved relatives who told us the service they had received was excellent and that their loved ones had received all care they needed. We were told that during the last days of life, the staff were very kind, compassionate and caring with not only with their loved ones
but the whole family. Relatives told us that the staff had gone above and beyond their roles and were always contactable no matter what time of day. The patients relative had an episode in hospital during the patients end of life care phase and said the staff were amazing. Staff were described as ‘angels in disguise, so kind and caring’.

Staff told us that a palliative care patient who was in the last days of life and unable to access private homecare. The palliative care respite team fast-tracked the patient a full package of care with the support from the district nurses. This enabled the patient to be cared for by the respite team in the last days of life in their preferred place of care.

We attended two home visits following consent from the patients. Throughout both visits we observed how staff ensured sensitive communication took place between staff, the patient and those identified as important to them. During all interactions staff involved the patient, giving advice on symptom control, nausea, diet and fluids. Conversations also included the patients’ relatives as staff were committed to working in partnership with both the patient and their families. Following the assessment, we observed effective communication with external parties that were in the best interests of the patient. The GP and other healthcare professionals were contacted for advice and input into the patients care.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. We heard staff from the team talking to patients on the telephone and the conversations were empathetic and compassionate.

We reviewed a questions analysis on the patient/carer experience in relation to bereavement that incorporated 47 responses for the period 1 to 18 March 2019. Eighteen questions were asked in relation to bereavement support and 89.36% of people as a combined total were happy with the care received. However, 28.26% of patients/carers were not offered the support from the hospital chaplaincy service.

To improve bereavement support we were shown a draft copy of a bereavement booklet that had recently been developed. This was awaiting trust board approval. The new booklet was more compassionate in that it was not just giving the relative/carer a death certificate, it contained more information that patients felt was needed. This had been developed with the help from patients and their family, the end of life steering group in which patients also attended and advice was also sought from the publisher to ensure it was patient friendly.

Counselling, family support and appointments with a psychologist were available via the local hospice for patients and their families and staff. Staff we spoke to told us that this service was a great help when caring for complex patients. The mental health and the occupational health team at the trust also provided counselling when required.

Staff told us about how the needs of families and carers were important to the dying person and they told us about the support groups offered at the local hospice. For example, there was a monthly bereavement support group that had a trained counsellor present, carers support and symptom management advice available from the day services team. A leaflet was available regarding ‘what to expect when someone is dying’ and staff told us how they spent time with families to support them through this period.

Memory boxes were completed for children whose parents had died. The memory box created an opportunity for children to talk about their loved one and could help the child to open-up about their feelings.
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. Care was holistic, and carers and family members were involved in the delivery of care.

We saw that social assessments of families and support mechanisms were discussed as part of the multidisciplinary meeting.

We observed a communications diary in a patient record. The diary was for staff, patients, carers and their families to write in so that all involved could see if anything was required during the patients care.

We reviewed patients notes and observed that patients and their relatives were involved in their care and the decision-making process. Discussions were documented on the choice of preferred place of care and the care pathways required for gold standard care.

We observed a ‘who’s your hero award’ that the palliative care team had received for going above and beyond their job role. The team manager and a clinical nurse specialist had gone to a patient’s home in their own time to clean and move furniture around so that a bed could fit in and the patient could be at home as this was their preferred place of care.
Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided services in a way that met the needs of local people. There was joint working with the local council and numerous charities.

The specialist palliative care team provided support to other services and professionals that delivered palliative care to ensure consistency in their approach and to maintain quality in both care and the documentation of care.

Provision of specialist palliative care support was available for patients, families and carers experiencing complex symptom issues.

Caseloads were kept light at the weekends to ensure the service remained responsive. A rapid specialist team member had protected time for emergency visits.

A special patient note was implemented by the end of life care facilitator which enabled GP’s to describe information about patients with complex health and social needs. Staff working in the out of hours service told us that this was invaluable as occasionally they had no prior knowledge of the patient that they needed to assess. The notes were red, green and amber (RAG) rated so that knowledge about patient risks could be shared to external parties if required. For example, dependent on the score the notes could be emailed to the ambulance services, out of hours GP surgery or the NHS 111 line. Staff told us that these notes were beneficial as they showed whether the patient was at a risk to themselves or others and enabled staff to assess risk and plan visits to meet the patient’s needs. The special patient notes also identified if an advanced care plan was in place.

The palliative care respite team provided a co-ordinated night sitting service with Marie Curie for patients and their families. This service enabled patients to stay at home for longer and supported the carers of the patient. The team had regular sits for palliative patients and those with long term conditions and provided the service for when patients relatives wanted some respite. The sitting service would also be provided in the hospital setting as staff were passionate that no patient died alone. Dependent on capacity, staff in the Glossop neighbourhood could access the local hospital in the Derbyshire area for night sits.

The service was working with commissioners, district nursing teams, palliative care services and other external partners to take forward the ‘Hospice at Home Model of Care’. This model is an integral component of community end of life care which brings in the skills, ethos and practical areas associated with the hospice movement into the home environment; putting the patient and those who matter to them at the centre of care. This was work-in-progress at the time of inspection.

We observed excellent collaborative working with all services in the intermediate tier service which helped to prevent unnecessary admissions to hospital at the end of life. For example, staff at the trust’s ‘Digital Health Centre’ had reduced the number of hospital admissions. Staff in the centre had trained residential, care home and community response service wardens to take basic observations on patients whilst using Skype such as; taking blood pressure readings and monitoring heart rates. Staff told us that the team dealt with situations that potentially could prevent someone from staying at home, such as unresolved symptom control. Swift actions taken by the integrated service provided the right level of support so that patients could stay in their preferred place of care.

A partnership engagement network involving the local council, charities, patient participation and the public had been attended by staff in the end of life care service. Patients had voiced that the
advanced care document contained medical jargon that was difficult to understand and difficult to complete. Following these concerns, a workshop was implemented to discuss making a new advanced care planning document which would be easy reading for patients and their families. We reviewed the new document, titled ‘My Care My Way’ and observed that it was a simple document with easy read questions. Feedback gained from patients and the public had been positive and the document was now being rolled out throughout acute and community services.

The Glossop neighbourhood team had led on the design of a ‘Gold Folder’ which was a folder for patients to keep all their documents and wishes in one place. This ensured better communication between professionals, patients and their families in the last 12 months of life. The gold folder was developed as part of the trusts 100-day challenge and the concept was that the folder stayed with the patient at all times; during any appointments attended.

We reviewed the gold folder and observed that it had various resources for patients’, for example, a directory of services relevant to them, a community care pathway, ‘My Care My Way’ booklet, Sheffield Profile for Assessment and Referral to Care (SPARC) document and a page with messages and comments. Staff told us that with the help from external parties and patient participation they had designed and chosen the colour gold as it tied in with the gold standard framework. We observed that the folder did not mention anything about palliative or end of life care on the front of the folder which was what patients and their families had requested.

A palliative care ambulance was designated from the local ambulance service for end of life care patients and would respond within two hours for patients on rapid discharge. There was a service level agreement.

Meeting the needs of people in vulnerable circumstances

There were information leaflets available for patients and their families, for example cancer and dementia, coping with depression, coping with fatigue, pain and a list of mood boosting books. Although we did not see any leaflets in other languages we were told that these could be sourced through a local charity if required.

A translation service was available through the local trust and an interpreter could be booked for visits if required.

Staff told us that depression and anxiety assessments were completed by the palliative care nurses. Working closely with GP’s any concerns were highlighted. In addition to this, if the patient was known to the mental health or learning disability team then collaborative working was carried out.

If a patient was discharged from their service with mental health needs, then a discharge summary would be sent to the GP and the mental health team for the area concerned.

We observed a discussion in the multidisciplinary meeting at the local hospice on arranging a best interest meeting for a vulnerable patient. The patient had a diagnosis of dementia and a visit was arranged for the palliative care consultant to speak with the family and to arrange the meeting with the family and other health professionals.

We saw that there was provision of urgent specialist advice for patients approaching end of life with the offer of night sits alongside Marie Curie provision. Staff told us that if there was no night sitter available for a patient and their family then the palliative care respite team would work with the out of hours district nurses to support the family.
We service had a dedicated care home clinical nurse specialist who provided ongoing palliative care support, education and training provision, including delivering the 'Six Steps Programme' in residential and nursing home settings. The Six Steps to Success in end of life care included discussions as end of life approaches; assessment, care planning and review; co-ordination of care; delivery of high-quality care; care in the last days of life and care after death.

We observed that the out of hours and the single point of contact service had a list of palliative care patients that could potentially call for assistance even though they were not planned for a visit.

Each team had a mobile phone specifically for complex patients, this enabled patients to contact the district nurses or palliative care nurses directly rather than go through the single point of access. This gave patients direct access to the healthcare professional they required.

We asked staff in the district nursing service how they engaged with black minority ethnic groups and were told that they found it difficult to engage with these groups due to the limited use of end of life care services by the families, however staff told us they were learning as they went along and more patient engagement days held within the community setting would help to overcome these obstacles. We were told that no training had been given on end of life care for this group of patients’ and it was an area of training that was required due to the cultural diversity in the Tameside and Glossop geographical area.

We were told by staff that for patients with a terminal diagnosis who had children, the school nurses would be contacted to ensure their needs were met. Staff told us this was essential for the grieving process and that the end of life care services did not stop once a loved one died.

We observed a palliative care board in a district nursing office and were told by the team members that each neighbourhood had a board to identify palliative patients. The board also ensured that staff were aware of the gold standard framework meetings at the GP surgeries so that someone would attend.

The hospital chaplaincy service was not affiliated to any one religion or belief and would endeavour to source the right service for the patient and their families, for example an Iman for the Muslim faith, Pujari for the Hindu faith and a Priest for the Catholic faith.

Access to the right care at the right time

People could access the service when they needed it. There was a single point of contact team that took all referrals for all departments. Referrals were prioritised by a nurse and sent to the relevant departments. End of life care patients were prioritised as priority one and seen within four hours. We asked for data to see if these targets were met but managers said these were not currently audited but would be part of the audit programme going forward.

There was a daily triage process which was completed by the palliative care and palliative care respite care teams. However, due to capacity and demands of the service a new process was being piloted where one staff member would complete the triage process. This would leave more time for the other team members to complete other tasks in their workloads. At the time of inspection this development was out for comments within the team.

There was an out-of-hours hospice line for advice for both staff and patients and a triage process for complex patients within end of life care. In addition to this there was a dedicated complex phone line for patients with complex needs.
The trust provided the following data on the largest Black and Minority Ethnic (BME) groups within the trust catchment area of Tameside. The largest ethnic minority group within the Tameside area is White Europeans with 2.4% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Europeans</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian British: Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian British Bangladeshi</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian British: Indian</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – Accessibility tab)

The trust identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’ and has provided data based on the period from November 2017 to October 2018.

There was no set target for any of the teams/services for time from referral to initial assessment or from initial assessment to onset of treatment within community health services for end of life care.

The trust noted that for Macmillan nurses, the target for non-urgent referrals is within 10 days and for urgent referrals is within 24 hours.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of in-patient ward or unit</th>
<th>Days from referral to initial assessment Actual (median)</th>
<th>Days from initial assessment to onset of treatment Actual (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crickets lane health centre</td>
<td>Macmillan nurses</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Palliative respite care</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: CHS Routine Provider Information Request – Referrals tab)

We reviewed the data given for referrals to and discharges from end of life care for the period December 2018 to February 2019. See table below:

<table>
<thead>
<tr>
<th>Referrals to end of life care:</th>
<th>December 2018</th>
<th>January 2019</th>
<th>February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macmillan nurses</td>
<td>41</td>
<td>50</td>
<td>47</td>
</tr>
<tr>
<td>Palliative respite team</td>
<td>36</td>
<td>53</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharges from end of life care:</th>
<th>December 2018</th>
<th>January 2019</th>
<th>February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macmillan nurses</td>
<td>25</td>
<td>38</td>
<td>35</td>
</tr>
<tr>
<td>Palliative respite team</td>
<td>26</td>
<td>30</td>
<td>22</td>
</tr>
</tbody>
</table>

We were told by staff that if a patient needed to be admitted to hospital by the palliative care team they would liaise with the trust’s acute oncology team which omitted the need of a GP visit.

Emails with patients details and dates of discharge were sent to the palliative care team from the local hospice if a patient was discharged home. This ensured that the patient care pathway was maintained effectively.

There were two designated end of life care beds in the trust community inpatient department. These beds had been assigned four weeks prior to our inspection and the end of life care team provided an in-reach service to this facility. However, staff told us that for patients to be admitted to these beds they would have to be admitted to the trust via the Accident and Emergency...
department. Although this new initiative was welcomed by the specialist palliative care team and the district nursing team, it was work-in-progress and required further development so that patients could be referred to the beds quickly. Management told us that they were considering supplementing the existing GP cover using advanced nurse practitioners. We were told that this would be commenced in the financial year April to March 2020.

We were told by management in the specialist palliative care team that they were looking at the criteria for referral into the end of life care service as a lot of the referrals could be seen by the district nursing team alone. We observed the draft electronic referral template which ensured resources were targeted to those in need of specialist palliative care intervention. The template known as the complexity and dependency scoring tool incorporated numerous subjects, such as palliative care, pressure care, medication and nutrition. The scores would then grade the complexity of the care needed and ensure the patient received the right healthcare professional at the time required.

We observed good integration between the extensive care team, social work and the end of life care team and were shown an example of how staff put a package of care into a patient’s home within an hour and re-enablement within three hours.

A system called ‘Tell us Once’ was set up by the local council which ensured that the end of life care services was notified of a death. This ensured that the team were made aware of a death and staff did not knock on the door of the patient’s home when on their visits.

**Learning from complaints and concerns**

Concerns and complaints were treated seriously. Complaints would be investigated, and lessons learnt shared with staff. However, we spoke to staff and they told us that there was inconsistency in cascading learning events regarding complaints and incidents and this was an area they would like to be improved now that they were an integrated service.

From February 2018 to February 2019, there were no complaints about community health services for end of life care.

*(Source: Universal Routine Provider Information Request (RPIR) and inspection discussion)*

From November 2017 to October 2018 there were 20 compliments received for community health services for end of life care (0.1% of all received trust wide).

Compliments were received in six months of the 12-month period. November 2017 and May 2018 were the months where the most compliments were received (7).

The trust did not provide a breakdown by subject for compliments received.
*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

Leadership

We were given a copy of the end of life care management structure which sat under the intermediate tier service within the trust. In this structure, the service had an integrated neighbourhood reporting and governance structure accountable to the executive management team. Each neighbourhood, including the new models of care and health inequalities fed into a programme leads meeting and clinical advisory group. Within the senior management structure and the reporting lines we observed that the intermediate tier service demonstrated the service had managers and staff at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Management told us of the challenges ahead in integrating and combining the services under one roof to ensure good, sustainable quality care and this was evidenced in the action plans and timeframes in the palliative care end of life care programme board.

Staff told us that the new organisational changes were positive and they all felt supported by managers. Feedback from staff in the end of life care service were very positive about the support from the manager who was new in post.

Staff in the district nursing team told us that the new director of nursing was very visible and had an open-door policy; this was re-iterated by staff in the Glossop neighbourhood team and they also told us that the intermediate tier service director had offered staff to spend the day with them to show how the operations of the service ran. However, some staff in the service told us that senior managers were not visible in the community setting; although there were monthly forums that they could attend, without protected time in their caseloads this was difficult to access.

We observed communication boards demonstrating how the service was performing. Staff told us that this was a good way of communicating information from the trust board to staff on the ground.

Vision and strategy

The service had a vision and a strategy of what it wanted to achieve and plans in place to move the developments forward. The trust’s and the intermediate tier service’s vision was to improve the health and quality of life in the diverse population that is encompassed in the Tameside and Glossop area and provide leading local care with the involvement of staff, patients and their families and internal and external groups that represent the local community.

The end of life care service also had a vision that by working collaboratively, staff, patients and their families could have equal access to health and social care services and receive safe, effective and compassionate care closer to their homes.

We spoke to end of life care service staff within a focus group and all were aware of the trust values: safety, care, respect, communication and learning. Staff also told us that they felt there was now a clear direction for the service and all felt that they were part of the delivery of this vision.

End of life care priorities had been identified and action plans were in place to develop the service. We saw a plan of action from the palliative and end of life care programme board which highlighted areas of care required to be completed to ensure everyone received good end of life care. Areas discussed were identification of people who may be in their final stages of life, care delivery and advanced care planning to ensure people were offered the chance to create a
personalised care plan, after death care and bereavement, education and training and information technology and its structure. Although the plan was comprehensive, there were no set dates evident for achieving these goals.

We were told by senior management that they were considering the introduction of a co-located service that would see a central hub for all referrals and requests, appropriate allocation of professional support and in-reach into the hospital. This would facilitate consistent medical oversight for patients receiving palliative care.

The trust currently had an electronic summary care plan (EPaCCS) which enabled communication from the GP to the trust to be carried out. The vision of the community services was for this system to be implemented so that other external parties, for example NWAS and the local hospice could utilise it, which would ensure everyone could access the patient records.

**Culture**

We saw good relationships between the teams. All staff told us that they felt supported and were proud to be part of the intermediate tier services.

The culture of the service was very open and honest, and staff told us that it was a good place to work. Staff told us that working in end of life care was sometimes challenging but they all felt that they worked constructively and shared responsibility to deliver good quality care.

Newsletters and bulletins were shared through team meetings and emails.

We were told by management that two clinical nurse specialists within the palliative care team provided mindfulness sessions to staff. These had been well attended and staff told us that these sessions had been positive for the wellbeing of the team.

Discounted massages were available to staff as part of the trust’s wellbeing strategy. Staff told us that they had not accessed this yet but were happy that they were on offer.

The service had identified that there was a risk that staff could get assaulted or experience threatening behaviour towards them if they were going out alone to assess patients in their own homes. This could result in personal injury, work related stress and/or anxiety and potentially a reduced capacity to deliver the service.

We spoke to staff about lone working and were told that they did not have a specific lone working device. However, all staff used their personal mobile phones to text a team member they were on shift with to say that their visit had finished. This would then be acknowledged with a text back. We observed a flowchart on lone working for staff to ensure safety was paramount within the team. Staff told us that risks would be looked at prior to the visit and a buddy up system would be used if required. Staff would text the co-ordinator if they could not return to the office when they finished work.

**Governance**

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. We saw that the integrated neighbourhood model incorporated new models of care, such as single point of contact and social prescribing as well as health inequalities such as frailty and falls. The involvement of these teams within the intermediate tier service helped to provide high-quality palliative end of life care.
We reviewed the action log from the care delivery and advance care planning workstream group. This had action plans and timeframes documented. Examples of actions to be undertaken were to ‘establish a gold folder working group’ and ‘report to district nurses on lack of attendance to gold standard framework meetings’. We also reviewed the palliative and end of life care programme board action log and the system-wide palliative and end of life care project action plan. Both had actions and timeframes which guided their processes. These were work-in-progress at the time of inspection.

We reviewed meeting minutes taken from the palliative end of life care programme board. For the minutes in January 2019 it showed attendance from a variety of healthcare professionals, such as the integrated neighbourhood manager, the team leader for end of life care, director of quality and safeguarding and external parties from the local hospice. Various items were discussed, such as the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document and agreement was made to roll the form out across the whole health economy.

We were told by staff that a health and care advisory group met quarterly. This group fed into the programme leads meeting and clinical advisory group under the executive team at the trust. Recent discussions held were on the IPOC and advanced care planning document.

We reviewed the terms of reference for the palliative and end of life care programme and this demonstrated good collaborative working between the trust, the community services and external parties. However, these had been developed in 2014. We raised this with managers and were shown a copy post-inspection of the minutes taken from the end of life steering group which demonstrated that this had been discussed. A draft terms of reference would be implemented for the next meeting in June 2019.

We were given a copy post-inspection of the end of life care services continuous improvement plan which was a working document for the development and improvement of the team. These plans were discussed at intermediate tier service continuous improvement meetings.

Management of risk, issues and performance

The service had effective systems in place for identifying risks and there was planning to eliminate or reduce them.

The end of life care service had a risk register, and we saw that key risks identified, included, no palliative care consultant, financial budget and risk of lone working. We also saw a quality and performance budget and were told by the team leader that any risks that had a total above 12 were escalated to the trust board.

There was a risk to the safety of staff when entering and leaving the building at the Crickets Lane Health Centre. This was identified on the trusts risk register. We saw that all the out of hours and single point of access staff were trained in the management of conflict resolution as part of their mandatory training. The local police team patrolled the area regularly to support staff. Quarterly meetings were held at the trust about security and personal security equipment was being considered via the security management group.

Staff we spoke to were clear about their roles and responsibilities. Performance was monitored through appraisals and personal dashboards that staff would bring to their one-to-one meetings. Staff told us that this was a clear and effective process and if either party had any concerns these would be discussed during the meeting.
We were told by management in the Glossop neighbourhood that residents did not have a ‘statement of intent’ as they fell under a different coroner due to the geographical area. This was an item that the service was looking at and was work-in-progress at the time of inspection.

Medicines and Healthcare Products’ Regulatory Agency (MHRA) alerts were emailed to staff and a central response was emailed back to confirm that they had been read and understood.

Information management
The service collected, analysed and managed information well to support all its activities
The service was in the process of becoming paperless and the teams were working together to achieve this.

Process mapping was being completed by the service manager to help to reduce duplication and improve quality. In addition to this, management told us that they were in the process of improving their audit programme to ensure all activity was measurable so that improvements could be made if required. A head of patient experience had recently been appointed at the trust and the community services were planning to work together to look at patient outcome data within end of life care services.

Guidelines were available for staff to access either electronically or in a resource file located in the office areas.

We were told by staff that there was no information technology support at weekends. If the electronic management system crashed, then information could not be shared. There had been no incidents up to the time of inspection. We saw that this was not on the risk register and this was highlighted to management again at the time of inspection.

Staff told us in the Glossop neighbourhood that the Wi-Fi connection was poor in this area. This created problems at times as patient notes could not be accessed when on home visits. This was not on the service risk register.

An electronic dashboard had commenced in January 2019 for end of life care services, this demonstrated service deprivation in the neighbourhood areas; the darker the colour of the geographical area on the map the more deprivation was in that district. In addition to this the dashboard demonstrated the service demand that they had captured from the electronic management information system.

Engagement
A bereavement group had been established in the Glossop area following the ‘National Voices Bereavement Survey’. The ‘National Voices’ survey is a national survey that was commissioned by the Department of Health in 2011 and 2012 and NHS England from 2013 and collates and documents views of bereaved people from informal carers. The bereavement group was supported by the end of life care facilitator and was set up by a member of the public. Feedback had not been documented but we were told by staff that verbal feedback of this service had been positive, and families were very grateful that this service was available to them.

Staff in the palliative care service told us about an event that was held on ‘dying matters’. This event had craft activities, virtual art of the dying art gallery (this is an exhibition of art work by people who have recently died, or their friends and family have made, for example items within the virtual art could be photography, paintings, ceramics or drawings), information from funeral
directors, celebrants and solicitors, local charities and a performance by the local choir. The goal of the event was to create a friendly space for people to ask questions around end of life care issues, such as making a will, planning a funeral or coping with bereavement. Staff told us that the event was welcomed by the public and future events would now be carried out following its success.

Managers and staff worked together in partnership with GP’s, social care providers, patients and their families and volunteers to deliver joined up health and social care services for patients in Tameside and Glossop. A ‘Care Together’ programme to help bring these different services together had been established so that a different approach to early intervention and prevention would be achieved. The key approach was to prevent people becoming ill in the first place and to design and deliver services which focus on health and care needs of the individual.

We saw minutes of meetings from the patient and service user experience group. For example, patients had fed back to the trust that they did not understand their medications on discharge. Changes were made following the feedback given so that instructions were easier to understand, and medical jargon eliminated. In addition to this, action plans and timeframes were documented ensuring that progress was maintained following the feedback.

Learning, continuous improvement and innovation

NHS Trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether 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 to continue to be accredited.

The trust did not report any accreditations awarded relevant to community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – Accreditations tab)

The service was committed to improving services. All teams worked collaboratively with all partners, both internally and externally to enhance end of life care.

The service had recently welcomed a delegation of people from the state of New York who had come to the United Kingdom to see the new ‘Digital Health Service’ that was being used within the intermediate tier service.

Staff told us that members of the service had attended a conference in London to present a poster on integration of working. Nurses from Finland and Thailand had visited the clinics to look at the work. In addition to this, conference calls with staff in Australia had been completed due to the work by the teams under the intermediate tier service service.

We saw a ‘Patient Choice’ award presented to the palliative care and palliative care respite team in 2018 for the ‘Everyone Matters’ annual award given by the trust. In addition to this we observed a nomination for this award for the palliative care respite team and the integrated urgent care team for their care in the community.

We observed a board within the health centre of a tree with the title ‘DIG’NE’TREE’ and various words surrounding this, such as silence, individuality, listening and respect. Staff were proud of this board and it re-in forced their values.
The service had received the 'Daisy, Dignity and Care Award' 2017 which would run for the next two years. This award demonstrated that the environment ensured that dignity in care was at the forefront of everything the service did.
Community inpatients services

Facts and data about this service

The Stamford Unit is a 96-bedded unit situated adjacent to Tameside General Hospital. The unit comprises of three floors, accommodating 32 patients on each floor, in single rooms with ensuite facilities. The unit can accommodate one bariatric patient. As another provider closed their intermediate care facility, this transferred over to Tameside and Glossop Integrated Care NHS Foundation Trust and formed part of the Stamford Unit in June 2018.

The unit provides this care in a community setting with nursing, medical, therapy and social care interventions available for patients.

The unit mainly had patients who were resident in the Tameside and Glossop area and registered with a local GP. The unit accepts patients who have been discharged from acute care who are identified as needing continued multi-disciplinary assessment or provision of ongoing care, including complex discharge planning and in-patient intermediate care. The admission process to the unit uses a paper-based referral system, completed by the referring ward/unit. This is then submitted to the integrated urgent care team (IUCT) who would then ensure the patient met the criteria for admission.

The onsite team comprises of nurses, therapists, care support staff and social workers, with registered nurses based on site 24 hours per day, seven days per week. Specialist teams, such as speech and language therapy, dietetics, Digital Health and the intravenous community team, in-reach to the unit in line with patient needs. There was seven-day access to medical support. The unit accepts patients from the age of 18 years and above and offers a five-day therapy service.

Daily multidisciplinary team (MDT) board rounds (supported by IUCT and extensive care staff) take place to enable good communication and facilitate proactive management of discharge planning. A weekly multidisciplinary team 'length of stay summit' also takes place to ensure multi-agency scrutiny of plans to ensure assurance of safe and timely transfer.

The ethos of the unit is to support patients in their transition from an acute stay in hospital to making their next step towards returning home.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The inspection took place over three days and during this time we spoke to eight patients and two relatives/carers and 34 staff members, inclusive of senior leaders, managers, medical and nursing staff, students and domestic staff. We reviewed a total of 11 patient records and observed daily activity and clinical practice within the unit. We also held two focus groups during inspection. We also reviewed data relevant to the department that we received before and after the inspection which was provided by the trust.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

We saw that the trust provided a variety of training in key skills to staff and the frequency of this varied. Training was delivered as a mixture of both face to face and electronic.

<table>
<thead>
<tr>
<th>Training type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>Yearly</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>Yearly</td>
</tr>
<tr>
<td>Fire safety</td>
<td>Two yearly</td>
</tr>
<tr>
<td>Health and safety</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Infection, prevention, control</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Mental health training</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Safeguarding adults-level one and two</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Safeguarding children-level one and two</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Safeguarding children-level three</td>
<td>Annual review</td>
</tr>
</tbody>
</table>

We were also told that mandatory training compliance was reviewed as part of the appraisal process, so managers had clear oversight of who was outstanding, or due for training updates. Managers received a report every month and this would highlight who was coming up to expiry with training. We saw evidence of actions taken to address this, as some staff members were nearly due for a repeat of their fire safety training, so managers had initiated a fire safety lecture to ensure staff remained compliant. To manage this effectively, managers used a RAG rating system to prioritise training needs that flagged as red, whilst also planning to address those highlighted as amber to retain compliance.

Mental Capacity Act training was completed by all qualified nurses.

The service was working hard to try and ensure all staff members were up to date with training to meet the trust target of 95% for the completion of mandatory training. Compliance for manual handling level one was 100% for the unit.

Qualified nursing staff

A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified nursing staff in community inpatients services is shown below:
In community inpatients services the trust had an overall mandatory training compliance rate of 94.6% for qualified nursing staff. The 95% target was met for four of the seven mandatory training modules for which qualified nursing staff were eligible.

It should be noted that the training modules not meeting the target is due to only two eligible staff not having completed the training, so the performance should be taken in context when dealing with small numbers.

The compliance rate with resuscitation training in basic life support for community inpatients was 85.9%.

Medical staff
The trust did not directly employ any medical staff within community inpatients services.

There was a service level agreement in place with another provider for medical provision. Following inspection, we received information from the trust to say that the medical staff provider had a staff database of training completed, which included basic life support, infection control, mental capacity act/deprivation of liberty safeguards, learning disability awareness, general data protection regulation (GDPR), domestic violence, information governance and prevent training.

Qualified allied health professional staff
A breakdown of compliance for mandatory training courses from December 2017 to December 2018 at trust level for qualified allied health professional staff in community inpatients services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In community inpatients services the trust had an overall mandatory training compliance rate of 100.0% for qualified allied health professional staff. It should be noted this only relates to four eligible staff, so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

**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.

Staff could access a safeguarding page on the intranet, which was relevant for both adults and children. Information on the Mental Capacity Act and deprivation of liberty safeguards was available and there were flow charts for how to action deprivation of liberty safeguarding on an adult, aged 18 years and older. There was a policy for interagency working and vulnerable adults and we saw these to be in date.

The senior staff from the unit had undertaken additional training to become a safeguarding adults’ manager (SAM), with a plan for all the band six staff and above to complete it. There was a safeguarding adults’ manager on the unit each day.

Staff we spoke to were able to explain what they would do if they had any safeguarding concerns and the process of escalation, as this would always be passed to the most senior nurse to manage and they would contact the safeguarding team. If safeguarding concerns were raised, there was a strategy meeting to gather all the evidence and the trust safeguarding team would be involved who would liaise with the local authority as needed. We were told that the safeguarding team were very supportive and that a member of the team regularly came to the unit. Patients also had a body-map completed on admission routinely and one was also completed on discharge.

On asking staff about safeguarding supervision, we were told that there was no formal safeguarding supervision delivered on a regular basis, but that they would always be able to discuss concerns, or issues with colleagues and peers if need be. That said, if staff had been part of a case that had been managed by safeguarding, staff were contacted by email and invited to discuss any issues that may have arisen from the case. The safeguarding adults’ managers had yearly meetings and supervision with a member of the safeguarding team and they discussed cases they had been part of as part of that meeting. We were also told about an operational group that all leaders of different disciplines were invited to. In the group, staff would share a case to review how it had been managed and if there had been any gaps in service for learning and improvement.

The unit also had a board displayed dedicated to safeguarding and things for staff and patients, relatives and carers to be aware of.

**Safeguarding training completion**

The trust set a target of 95% for completion of safeguarding training.

**Qualified nursing staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December
2018 at trust level for qualified nursing staff in community inpatients services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>26</td>
<td>28</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>25</td>
<td>28</td>
<td>89.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community inpatients services the trust had an overall safeguarding training compliance rate of 91.1% for qualified nursing staff. The 95% target was not met for either of the two safeguarding training modules for which qualified nursing staff were eligible.

It should be noted that these training modules not meeting the target is due to only two to three eligible staff not having completed the training, so the performance should be taken in context when dealing with small numbers.

**Medical staff**

The trust confirmed that they received assurance that training undertaken by medical staff who worked on the unit as part of a service level agreement did include safeguarding adults and children training.

**Qualified allied health professional staff**

A breakdown of compliance for safeguarding training courses from December 2017 to December 2018 at trust level for qualified allied health professional staff in community inpatients services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community inpatients services the trust had an overall safeguarding training compliance rate of 100.0% for qualified allied health professional staff. It should be noted this only relates to four eligible staff, so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

**Safeguarding referrals - adults**

The trust made eight safeguarding referrals concerning adults within community inpatients services from December 2017 to November 2018, four of which were made in February 2018.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

**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.

The unit was visibly clean. Communal areas had hard flooring that was easy to clean, however all the bedrooms had carpet. We reviewed the cleaning schedules for the unit, which included detail of the carpets being steam cleaned at each discharge, with a shampoo clean after the discharge of a patient with an infection. On each floor, there was one small dirty utility room at the end of a corridor, which was opposite a fire exit. The area between the sluice and the exit was carpeted. We were told that National Health Service Improvement (NHSI) had been to review the unit and had referred to the carpet, particularly in this area near the sluice on each floor. Due to lack of storage space, commodes were stored in the sluice, which took up a lot of room. There was a plan for the carpet between the sluice door and exit door to be removed and a different flooring fitted. This would accommodate the storage of the commodes at the end of the corridors, after they had been cleaned in the bathroom.

We spoke to two of the domestic staff who regularly worked on the unit. One of them showed us the cleaning schedules they signed after cleaning each of the bedrooms and we saw them cleaning the rooms during inspection. The rooms were all visibly clean and all the patients and families we spoke to, had no concerns with the cleanliness of the unit. On the discharge of a patient, the rooms and carpets were cleaned, but if the patient had been infectious, there would be a much deeper clean completed.

The bedrooms had long material curtains. We were told that these were cleaned every few months. Following inspection, we reviewed the cleaning schedules for the unit, which were very detailed and had been reviewed and revised in February 2019. We were told that the plan was that the curtain and blinds clean/change would be included in the four-monthly periodic work schedule. However, we did not see any evidence of dates when the curtains had been removed and cleaned. We were told during inspection though that changing the curtains in bedrooms was part of the standard process within a ‘deep clean’ which took place when a patient had one of eleven possible infections. The trust told us, it was reviewing its governance processes in relation to the formal recordings of ‘deep cleans’.

Staff told us that there had been an outbreak of influenza on one of the floors of the unit and that as a result, that floor had been closed to new admissions for the period of one week. As the situation had been managed so effectively, the unit had received recognition for the management of the infection.
On entering the building in the reception area, there was a table with hand gels and clear signage to ask visitors to apply gel to their hands on entering reception and before admittance to the unit itself. Staff at reception were efficient at asking people to apply gel their hands if they had not already done so. Hand gels were available at regular points along corridors throughout the unit and we observed staff to be using gels and washing their hands.

We reviewed the hand washing audits completed by the unit for December 2018, January and February 2019 and we found that compliance had been 100% for all three of these months. The audits were completed on a variety of staff members of varying discipline and grade and each person had also been assessed to ensure they were compliant with being bare below the elbow and free of stoned rings, watches, nail varnish or extensions. We saw all staff members to be compliant with bare below the elbow during inspection.

There was an infection, prevention and control nurse who frequently visited the unit. We were told that information regarding patients with any infections were discussed at bed meetings, so all the necessary staff members were aware. We were told that within the whole unit, there had been no Clostridium difficile infections for three months (Clostridium difficile is an infection that cause bowel problems and diarrhoea). The infection, prevention and control nurse was accessible and available to advise and support staff members within the unit as required.

PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2018, PLACE scores for cleanliness, dementia friendliness and disability at the trust were all higher than the England averages for small acute trusts, while the condition appearance and maintenance score was similar.

At site level, both sites scored above the England average for dementia friendliness. The Stamford Unit also scored above the England averages for disability and condition appearance and maintenance and like the England average for cleanliness. Tameside General Hospital scored like the England averages for cleanliness, disability and condition appearance and maintenance.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Cleanliness</th>
<th>Condition Appearance and Maintenance</th>
<th>Dementia Friendly</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tameside General Hospital</td>
<td>98.9%</td>
<td>93.5%</td>
<td>80.2%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>98.6%</td>
<td>95.0%</td>
<td>85.4%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Trust average</td>
<td>98.8%</td>
<td>93.7%</td>
<td>80.9%</td>
<td>84.4%</td>
</tr>
<tr>
<td>England Average (NHS small acute trusts)</td>
<td>98.1%</td>
<td>93.8%</td>
<td>77.7%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

Environment and equipment
The service had suitable premises and equipment and looked after them well.

From the reception area, there were double doors accessed via a keypad entry system, which led to a corridor and the further locked doors to the ground floor of the unit. There was a corridor with stairs and a lift to access the other two wards of the unit. All three floors had the same ward layout. This comprised of a long entrance area with bedrooms on the corridor, leading to a reception area and large communal area with seating for residents. There was also a piano and shelves with books in the area, as well as a large television. The ward had a very large kitchen area with dining tables and chairs and views of the garden. The ward then split into two opposite ends at this point with further bedrooms and storage areas.

The building in which the Stamford Unit was based, was leased from a private company. We were told that there was a staff member who worked for the leasing company, who was based on the unit and they were responsible for overseeing any repairs, or jobs and alterations needed within the building.

On each floor, there was one small dirty utility room and there was also a locked clean utility room which contained medications and dressings. All of which were seen to be in date and stored in a tidy and orderly way.

Each bedroom had long material curtains with tie backs, which may present a ligature risk. Staff told us there was a criteria for admission and patients would not be taken if there was a known risk of mental health issues being a primary condition and that patients admitted who had mental health concerns would be under close observation by nursing staff, within the ‘hub’ area which always had staff members observing it. During inspection we saw that there were ligature cutters available on the back of the locked door to the clean utility and all staff were aware of where they were, with senior staff having been trained how to use them effectively. There was a ligature risk assessment dated 19 February 2019 which identified potential ligature points. We were told that immediate action had been taken in response to this assessment, resulting in the removal of blinds from stairwells and in addition, some curtain tie backs had been removed and others cable-tied to prevent removal. The risk assessment and associated actions remained under review by the unit matron, the estates department and the building owners. Each floor had access to a defibrillator, airways and other equipment on a resuscitation trolley and we saw this to have been regularly checked.

There were four blood pressure machines on each floor, which we saw had been portable appliance tested (PAT) and were found to be in date.

We saw bins neatly stored and clearly labelled for clinical waste. None of the bins or the needle sharps bins were over-flowing and all were tidy, with sharps bins clearly dated.

Each bed had a pressure relieving mattress, which also had grab handles for the safe manoeuvre of a patient if there was a fire.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

As patients were admitted to the ward, they had an identification band placed around their wrists. During inspection, we randomly selected patients on each floor and saw they all had appropriate identification bands in place.

We reviewed assessments in the nursing care records. One of the assessments completed was the ‘skin bundle’. The ‘skin bundle’ can help prevent minor skin problems from becoming major pressure ulcers and it aims to identify to reduce pressure ulcers acquired in hospital and clinical
settings. At the time of inspection, the unit were proud to report that there had been 200 days without any new pressure sores. Staff told us that all patients reported to have a newly identified pressure damaged area were considered for photographic evidence.

Assessments also included the national early warning score chart (NEWS), which was used to record vital signs and other clinical observations giving a score to indicate what action might be needed. The unit was in the process of moving over to NEWS 2. We saw evidence that NEWS was being completed and patients regularly seen.

When staff had clinical concerns with patients, or if patients fell, there was access to digital health services from 7.30am until 10pm. After 10pm, medical staff were available via the service level agreement and could be used for medical reviews. In the event of an emergency, staff would call 999, delivering basic life support as required. Within the unit, there was an alert system to clearly indicate in which room someone was calling for assistance. The senior nurse on cover each day was also responsible for attending to the emergency buzzer.

During inspection, we did not hear the call bell ringing for very long periods of time, however, on speaking with patients in the unit, there were variable responses given in relation to the time taken for someone to come to assist them. We saw the trust falls policy, which was in date. The policy was to identify those at risk of falling and to review interventions needed to prevent a fall from occurring, as far as able to. The policy stipulated that all patients admitted to the Stamford Unit should have a falls risk assessment completed on admission. We also saw that any patient at risk of falling had a falling leaf symbol which was used against the patient name on the ‘patient safety and quality at a glance’ board and within the patient rooms so that all staff were aware of that individual being at risk of a fall. We also saw signs in the rooms encouraging patients to call for assistance, rather than risking a fall.

Senior staff told us that all falls were logged and that staffing numbers were reviewed if a patient was at further risk of falls. A root cause analysis was completed if a patient had a fall with injury and duty of candour was completed. We were told that a scrutiny panel reviewed falls, with involvement of the falls team, to decide if the fall had been avoidable or unavoidable and any lessons learned would be shared with staff members. There was a meeting planned with a company to review fall prevention products, such as mats, probes and crash mats. There was also a falls prevention action group that met monthly on the unit.

Although the trust did not have a falls prevention group, falls prevention was one of the workstreams within the patient safety programme board. We reviewed three months minutes from this meeting and saw that the falls group had been aiming to achieve a seven percent reduction each year for inpatient falls, over a three-year period. One of the emerging themes documented in the minutes of the September 2018 meeting, had been poor documentation, but documentation had been improved so it was easier to use. During our inspection, we saw that bed rail assessments had been completed, documented and reviewed within the records.

We reviewed the fire evacuation procedure for the unit. In the event of a fire, the fire brigade would be alerted in their first instance and a bleep indicating that there was a fire in the unit would also be raised with the fire officer in the trust, as well as other members of the acute trust. Within the unit, we were shown that each of the beds had a mattress which had grab handles, so that immobile patients could be dragged to safety on their mattress as required. We were also told that each room had a fire door and that many of the doors would offer protection for a 30-minute
period. At the time of inspection, although there had not been a practice run of an evacuation, we were told there were plans to do this.

**Staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The unit used an e-rostering system to manage their staffing. The e-rostering system enabled managers to review annual leave, sickness absence, staff skill mix and any movement of staff between areas. Staff members could also access the system to check their rota’s and make personal requests. Senior staff told us that band six staff also had access to the rota’s.

We were told that the staff requirements for the unit were two qualified nurses and six health care assistants on each shift, on each floor, but that they would try to obtain a seventh health care assistant dependent on the needs of the patients. The night shift requirement was slightly different in that the staffing requirements were two qualified nurses and four health care assistants on each floor. In addition to that, the matron worked between 8 am until 6pm, with the unit manager working a long day and two short days per month as a clinical shift. The other unit manager was off sick at the time of inspection.

Staffing was based on the needs of the patient on the unit. The dependency on each floor was reviewed on a weekly basis, to aid the planning of safer staffing numbers. The reviews considered varying factors, such as how many patients were requiring extra equipment or support, or if they were subject to a deprivation of liberty safeguard.

Staff told us that the staffing levels had not been sufficient, but that there had been an emphasis on staffing and things were improving.

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). NHS trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety.

Details of staff fill rates within community inpatient services for registered nurses from November and December 2018 are below:

**Community inpatient services – Stamford unit**

<table>
<thead>
<tr>
<th>Ward</th>
<th>November 2018</th>
<th>December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fill rate day</td>
<td>Fill rate night</td>
</tr>
<tr>
<td></td>
<td>(%)</td>
<td>(%)</td>
</tr>
<tr>
<td>Stamford Unit Ground</td>
<td>100.3%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Stamford Unit 1st Floor</td>
<td>99.4%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Stamford Unit 2nd Floor</td>
<td>100.4%</td>
<td>100.2%</td>
</tr>
</tbody>
</table>

(Source: Trust Board Meeting Papers January 2019)

**Medical staff**

The service had access to medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The service accessed medical cover through a service level agreement with another provider, who provided medical cover 8am-4pm seven-days a week, with 24-hour call out services also available.
A GP was also rostered to the unit for eight hours per day, seven-days per week (8am until 4pm or 9pm until 5pm).

**Qualified nursing staff**

The trust reported the following qualified nursing staff numbers for the two periods below for community inpatients services:

<table>
<thead>
<tr>
<th>Team name</th>
<th>April 2017 - March 2018</th>
<th>April - November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Stamford-1 L5</td>
<td>10.6</td>
<td>11.2</td>
</tr>
<tr>
<td>Stamford-2 L5</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Stamford-ground floor L5</td>
<td>11.8</td>
<td>13.1</td>
</tr>
<tr>
<td>TCU - Darnton ward</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22.4</td>
<td>25.4</td>
</tr>
</tbody>
</table>

The trust reported a qualified nursing staffing level of 88.4% in community inpatients services from April 2017 to March 2018. This increased to an over established rate of 140.4% from April to November 2018.

From April to November 2018, there were 9.8 more WTE staff in post than planned for and 11.8 more WTE staff in post than from April 2017 to March 2018. There was a decrease of 1.0 WTE planned posts between the two time periods.

The trust reported a qualified nursing staffing level of 0.0% in two teams in community inpatients services across both periods. One unit only moved across in summer 2018 onto Stamford-2 which accounts for the 0% staffing. The unit only operates on the three floors in the Stamford Unit.

We were told that there was one band six (senior staff nurse) on duty on each shift and in cases where there were not, then either the matron or unit manager would be on duty. There was also one senior staff nurse on each night shift.

On review of the staffing figures for February 2019, there were a total of six shifts unfilled with the required amount of staff, which equated to 80 hours, with one shift unfilled in January equating to 3.5 hours. Senior staff told us that in the instance of a shift being unfilled, managers would try to obtain staff from either the acute medical or acute surgical wards. If unable to recruit, they would manage staffing based on acuity.

**Qualified allied health professional staff**

The unit had a band seven occupational therapist joining the team and was also comprised of two band six physiotherapists, two band six occupational therapists, two band five physiotherapists, three band four therapy instructors and five band two therapy assistants.

**Vacancies**

We were told that there had been vacancies with registered nurses on the unit, although there had recently been five qualified nurses recruited, with two yet to start in post.

The trust set a target of 4% for vacancy rates. From December 2017 to November 2018, the trust
reported an overall vacancy rate of -9.9% in community inpatients services. Across the trust overall vacancy rates for nursing staff were 11.6%; for medical staff were 33.7% and for allied health professionals were 5.2%.

A breakdown of vacancy rates by staff group in community inpatients services at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total % vacancies overall</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>-13.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>-8.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>27.9%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>38.9%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>100.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>-9.9%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Negative vacancy rates represent an over-establishment for the relevant staff groups.

(Source: Universal Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover**

The trust set a target of 12% for turnover rate. From November 2017 to October 2018, the trust reported an overall turnover rate of 14.4% in community inpatients services. This did not meet the trust’s target.

A breakdown of turnover rates by staff group in community inpatients services at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Turnover rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>0.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14.7%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>16.9%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>14.4%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness**

The trust set a target of 4.2% for sickness rate. From November 2017 to October 2018, the trust reported an overall sickness rate of 5.2% in community inpatients services. This did not meet the trust’s target.

A breakdown of sickness rates by staff group in community inpatients services at trust level is below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual sickness rate (%)</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>3.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>4.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>5.8%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>6.2%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>5.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Sickness tab)

Nursing – Bank and Agency Qualified nurses

From December 2017 to November 2018 the trust reported 11,511.7 of the 136,227.0 available hours were filled by bank staff (8.5%) and 2,701.2 hours were filled by agency staff (2.0%) for qualified nursing staff in community inpatients services. There were 17,522.6 hours that needed to be covered by bank or agency staff but were left unfilled (12.9%).

The trust gave the reason of 'vacancies' for the usage of bank and agency staff.

Staff on the unit told us that they did use agency staff quite a lot to cover shortages and that this had mainly been for qualified nurses. However, the unit had just taken on five new staff nurses, with two due to start quite soon after our inspection.

We were told that a lot of the regular staff would do extra shifts on the unit, but if not, then the unit tended to use the same agency to recruit staff members. Staff from this agency had a local induction with the agency and an information pack was sent to them on confirmation of the booking. Senior leaders told us that it was clearly indicated if they had worked on the unit previously, or not, and a local checklist was completed on arrival to the unit.

A breakdown of bank and agency usage is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>December 2017 to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank</td>
</tr>
<tr>
<td></td>
<td>Hours</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>11,511.7</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

Nursing - Bank and Agency Non-Qualified nurses

From December 2017 to November 2018 the trust reported 33,894.7 of the 176,592.0 available hours were filled by bank staff (19.2%) and no hours were filled by agency staff for non-qualified nursing staff in community inpatients services. There were 39,493.3 hours that needed to be covered by bank or agency staff but were left unfilled (22.4%).

The trust gave the reason of 'vacancies' for the usage of bank and agency staff.

A breakdown of bank and agency usage is shown below:
### Suspensions and supervisions

During the reporting period from December 2017 to November 2018, community inpatient services reported that there was one case where staff had been suspended.

*(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)*

### Quality of records

Staff kept detailed records of patient’s care and treatment and the records were completed and managed appropriately.

Records were paper-based and these were kept in a locked room by the nurses’ station on two of the floors. Records were stored in a cupboard on one of the floors, which was not locked. We raised this at the time of inspection and saw these were moved to a locked room.

The medical, nursing and therapy notes were all documented separately, however there were plans to adapt the records moving forwards. Senior staff told us that the unit had been accepted to move to electronic documentation for nursing and therapy records. There were plans to trial the new record as a paper version for three months, before going live as the electronic record.

During our inspection, we reviewed 11 sets of records during our inspection and we found these to be contemporaneous and comprehensive, in most cases. All the records we looked at were dated and had clear signatures next to each entry, with only one record having a date missing on the admission checklist. However, some care plans were generic and not personalised. We reviewed the new recording template for the introduction of electronic records and considered this would improve this.

There were boards next to the nurses’ station with patient names on. On the top floor of the unit, they could cover names with flaps on the board, however there were no means of covering patient names on the other two floors. We raised this with the senior nurse in charge, who advised that this was being investigated.

### Medicines

The service has systems in place that ensured that medicines were administered and stored safely. Patients we reviewed had received the medicines they were prescribed in a safe manner.

Medications, inclusive of all types of medicines, as well as intravenous fluids were all stored in an organised way in locked cupboards, within a room with keypad entry. Controlled drugs were kept securely within the same room and, when checked, the amount of medication present matched that of the amount recorded in the controlled drug record book and all controlled drugs dispensed...
had been signed for. This was checked for the medication cupboards on all three floors and all were fully compliant.

A pharmacy technician attended the unit regularly to review stock levels and expiry dates of medications. We were shown a book which detailed a list of the unit requirements. We were told that there was a delay with patient take home medications, as the doctor would write this and the pharmacy technician would not start again until the next morning. This caused a delay and there needed to be 24-hours’ notice for a safe patient discharge and transport could not be arranged until the take home medications had been returned. However, when the new recording template was introduced, it would trigger the medications to be ordered via the discharge summary, which would decrease the delay in discharge.

During inspection, we checked the recording of the fridge temperatures, as some medications are stored in a fridge and the temperature should range between two and eight degrees and this should be checked daily. We checked all three fridges, reviewing dates over a three-month period and reviewing that the minimum and maximum temperature and any actions had been recorded. There was evidence of the fridges being checked daily throughout that time on all three floors within the unit.

We saw that there were tabards for staff undertaking the medication round to wear. The tabards were bright red with writing to indicate that the staff member was dispensing medications, in order that they were not disturbed and left to concentrate during that time.

We reviewed the medicines policy which we saw to be current and in date. There were monthly medication audits undertaken on the ward each month by the ward managers and we reviewed the results of these over a three-month period. As part of this audit, each night different beds were audited and prescription charts reviewed to see if there was the patient’s name, date of birth, omissions correctly documented, patient group directives correctly prescribed, signatures and end dates recorded, whilst ensuring that the right dose was given at the right time to the right patient, via the correct route. Over the three months prior to inspection, compliance was between 88 and 94 percent for the three floors.

Incident reporting, learning and improvement

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.

Staff told us they were encouraged to be open and honest and report incidents and did so on a regular basis. Staff received feedback from the incident they had reported. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff. This was reflected when there had been incidents of falls occurring and bed rail assessments had been introduced because of an incident.

We were shown in detail three incidents that had occurred, how they had been managed and what had been learned as a result and how this had been cascaded to other staff members. We discussed the falls scrutiny panel with several staff members. This panel reviewed any falls that had occurred to see if learning could be implemented to help reduce falls.
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.

From December 2017 to November 2018, the trust reported no incidents classified as never events for community inpatients services. 

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in community inpatients services which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

From December 2017 to November 2018, trust staff within community inpatients services reported three serious incidents. Of these, none involved the unexpected death of a patient.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

(Source: Universal Routine Provider Information Request (RPIR) – Serious Incidents tab)

During inspection, we reviewed the detail pertaining to the three serious incidents. On review of this information, we could see that incidents had been reviewed thoroughly, with appropriate root-cause analysis having been completed. There was evidence that duty of candour had been completed with each case. There was also information within the unit detailing how staff managed the duty of candour process.

All staff were fully aware of the policy for duty of candour and knew that in the first instance, there would be an apology to the patient and family/carer and if the harm had been moderate or serious, a letter would be written to the patient letting them know about the investigation.

Actions and learning were taken from these incidents and their outcomes. Actions had been added to the relevant action plans and followed up locally by teams. We were also told about a monthly overview of safety data, entitled ‘know your safety data’, which included information from the patient advice and liaison service, the friends and family test, complaints and trust wide data for the service.
The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports relating to community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Safety performance

The service monitored safety using information from a range of sources. The information was monitored over a period, to feed into service improvement.

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.

We reviewed safety thermometer information displayed on the main corridor of the unit and saw that data from the patient safety thermometer showed that the trust reported no new pressure ulcers for a period of 200 days.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Tameside and Glossop Integrated Care NHS Foundation Trust – All community inpatients wards.
Total CUTIs (4)

(Source: NHS Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

Patient-care and treatment was planned, delivered and monitored in line with current evidence-based guidance, standards, best practice, legislation and technologies.

Policies and procedures were available on the trust intranet page for all staff, making them readily accessible. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The documents contained flow charts and contact details of relevant agencies, as well as clear guidance for staff.

During our inspection, we looked at seven policies and all were in date. The guidance we looked at included safeguarding vulnerable adults, medicines policy, risk management policy and the infection, prevention and control policy.

One staff member we spoke to told us that they had been involved in a task and finish group last year to review the Intermediate Care Audit, NICE guidance and to review falls.

Nutrition and hydration

Staff ensured that they gave patients enough food and drink to meet their needs and improve their health, although patients reported food to often be cold.

Daily menus came from the acute hospital and were given out for patients to choose their preferred meal choices and the food was brought on a trolley from the acute hospital. Some of the patients we spoke with commented on the food often being quite cold after the time it took to get to the unit. We were told that the staff from the unit served breakfast themselves. Cereals and toast were available and patients commented on how good the porridge was when this was served. However, one patient also mentioned that they had been given plastic cutlery to use.

The service adjusted for patient’s religious, cultural and other preferences, with various choices available. Staff ensured patients had a jug of their preferred drink in the morning and would re-fill this as required.

The main kitchen on the ward was locked when not in use and was seen to be clean, tidy and clutter free, with a dining area overlooking the gardens. Within the kitchen area, there was a list for staff guidance on which patients needed supplements adding to drinks.

There were individual patient boards in each of the patient bedrooms and this detailed information, such as if they were a slow eater, so that staff were mindful of this, when giving out and taking away meals.

There were protected meal times of one hour for lunch and one hour for their evening meal, when most visitors were not allowed during these times, unless patients were part of ‘John’s campaign.’ ‘John’s Campaign’ was founded after the death of Dr John Gerrard in November 2014, when an infection meant his family were not allowed to visit and his health declined, so the campaign focuses on patients with dementia, who would benefit from having a relative or carer with them. We saw family members, carers and health professionals assisting with feeding when required and appropriate to the patient’s needs.

We were told about patients’ who required specialist feeds, sometimes given via a PEG. A Percutaneous endoscopic gastrostomy (PEG) is a medical procedure in which a tube (PEG tube) is passed into a patient’s stomach through the abdominal wall, most commonly to provide a means
of feeding when oral intake is not adequate. The amount of patient's requiring these feeds was taken into account when allocating staff numbers, so that these patients were given adequate time to receive their feeds. Patient's with specialist dietary requirements like this, were overseen by dieticians who attended the unit.

We were told that the trust as a whole had been undertaking a lot of work around improving nutrition and hydration and that the trust was leading on the International Dysphagia Diet Standardisation Initiative (IDDSI) rollout for thickening fluids and that there was on-going training for this being delivered throughout the trust. Weekly weights were completed on patients to monitor weight gain or loss, so that dietary requirements could be reviewed and altered in line with this, to ensure adequate nutrition.

Within the 11 records we reviewed, we saw evidence in each of those records of an assessment of nutritional status having been completed.

Within the main reception area, there were vending machines available for visitors to purchase drinks or snacks.

**Pain relief**

Staff gave pain relief to patients when required. There was an effective process to ensure patients’ pain relief needs were met and pain was well managed by the service.

Within the nursing documentation, we saw that the unit used a quality care tool, which included a regular review of pain.

We asked patients if they were offered pain relief and all the patients we spoke to told us that the staff frequently asked if they had any pain and would obtain pain medication for them, if required.

**Patient outcomes**

Managers 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. However, rehabilitation on the unit could be improved.

Some of the therapy staff we spoke to told us they had some frustration, as they did not always feel that they got to work with enough patients undergoing rehabilitation. During inspection, we were told that there were no 'breakfast clubs' or similar clubs running, to enable rehabilitation and independence for those it was appropriate for.

The Stamford Unit participated in the Intermediate Care Audit. The National Audit of Intermediate Care aims to take a whole system view of the effectiveness of intermediate care, to develop quality standards and patient outcome measures and to assess local performance against the agreed, national standards. We looked at the audit summary for the unit.

The audit was completed between May to August 2018 and related to information collected between April 2017 to March 2018. The information had been collected when there had been the two separate units, but as one had moved over to become part of the Stamford Unit in June 2018, the recommendations were based on the Stamford Unit. The analysis and interpretation of the audit results had been based on the National Institute for Health and Care Excellence (NICE) quality standard for intermediate care (QS173). Areas of good practice identified included:- percentage of patients waiting over two days for the intermediate care service as being less than the average, average bed occupancy was above the national average, indicating effective patient
flow and use of resources, the combined results for the two units indicated that patients were discharged home was above average and the service model of transferring patient’s rehabilitation from a bed based intermediate care unit to a home based intermediate care unit as part of the ‘home first’ basis, was functioning effectively.

Recommendations made following this audit had included:- improving the average length of stay to less than or equal to the average of 26 days, promoting a ‘step-up’ pathway from the community and the emergency department to intermediate care, reviewing reasons why the percentage of patients being discharged to an acute hospital was above the national average, the creation of initiatives to retain staff and to identify a staffing model for the unit, involving all levels of nursing and therapy staff and health care and therapy assistants to support improved functioning. During our interview with senior leaders from the unit, we heard of plans they had to address all the recommendations. We saw the service had halved the length of stay for patients over the last year.

We attended one of the weekly ‘length of stay summit’ meetings held on the unit. This meeting was multi-agency and was led by the head of patient flow for both the community and acute setting. Staff present at the meeting included the assistant manager from the integrated urgent care team, staff from the integrated urgent care team, therapy staff, the discharge co-ordinator and a social worker.

Therapists used estimated date of discharge and goal-set with patients. Therapy goals were reviewed weekly in the ‘length of stay’ summit meeting. We were told that there were no formal outcome measures used as standard.

Therapy staff told us that they would be involved in the sentinel stroke national audit programme (SNAP) if the patient came over for rehabilitation. They told us that they were involved in other audits, inclusive of critical care rehabilitation.

Staff on the unit participated in a variety of audits. Some of these included monthly audits of medication, controlled drugs, ensuring every patient had identification bracelets in place and hand washing audits.

**Competent staff**

Staff members were supported to deliver effective care and treatment through recruitment, training and development. There was a clear approach for supporting staff and managers appraised staff member’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Senior leaders told us that since Shire Hill had moved over to the Stamford Unit, the appraisal rates for that floor were lower, but managers were working hard to ensure all staff received regular appraisals.

From April to November 2018, 85.8% of all required staff in community inpatients services received an appraisal compared to the trust target of 90% (with a stretch target of 95%).

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April to November 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Qualified allied health professional | 4 | 4 | 100.0% | 90% | Yes
Support to doctors and nursing staff | 81 | 93 | 87.1% | 90% | No
Qualified nursing midwifery staff | 32 | 39 | 82.1% | 90% | No
Other non-medical staff | 4 | 5 | 80.0% | 90% | No
Total | 121 | 141 | 85.8% | 90% | No

(Source: Universal Routine Provider Information Request (RPIR) – Appraisals tab)

During inspection, we were told that the appraisal rate for the unit in February 2019 was 94.7%. We were told that new starters were not deducted from the figures, as they were given time to settle onto the unit before an appraisal was completed.

As part of the appraisal process, managers reviewed mandatory training compliance, as well as looking at what had gone well, or not so well for the individual staff member. Managers reviewed if the individual needed any further support with anything and would ask for suggestions to improve the service. Behaviours, performance and objectives were also covered as part of the appraisal and we were told that all staff members regardless of role or position received the same appraisal.

Several of the therapy staff we spoke to also told us that they had appraisals and received monthly one-to-one meetings.

Performance issues were managed on an individual basis by senior members of staff.

We were told that managers kept up to date with when staff were due for revalidation.

A variety of competencies were assessed. Electronic competencies, such as hoist use, the blood pressure machine and pulse oximetry were assessed. Staff told us that if there was any new equipment being introduced to the unit, it would not be launched, until all staff members had been trained.

Staff talked about plans to upskill band four therapy staff, with a view to expanding the therapy service over seven days.

The dementia specialist nurses were based on the ground floor of the building and they worked closely with the unit, offering advice, support and training as required. We were also told that staff received dementia training as part of their induction, which was delivered by the specialist nurses.

The unit supported student nurses undertaking their training, offering education and experience in many aspects of nursing and therapy care.

**Multidisciplinary working and coordinated care pathways**
All relevant staff, teams and services were involved in the assessing, planning and delivering of patients’ care and treatment and all staff worked well together to meet the range and complexity of patients’ needs, although therapy was only provided five days a week.

The therapy staff on the unit did not work at weekends, which meant therapy could only be offered five days during the week. Senior leaders did tell us that there were plans in place to upskill some of the lower band therapy staff, with a view to being able to expand the service over a seven-day period.

Care was delivered using a multi-disciplinary approach in care and treatment. This included support from nurses, GPs, social workers, physiotherapists, occupational therapists and support staff including discharge facilitators, care support workers, speech and language therapists, dietitians, district nurses and specialist nurses (e.g. mental health, admiral nurses, infection prevention and the intravenous therapy team).

There were also thrice weekly multidisciplinary board rounds.

Staff from all disciplines within the multidisciplinary team contributed to individual patient records and shift handovers. They all worked closely with integrated urgent care team. We were told that the community side of the integrated urgent care team supported patients with intermediate care requirements in their own homes, which included any relevant therapy support or nursing support and intervention. The service aimed to facilitate a seamless transfer of care from the hospital or bed based intermediate care services to home based care, with the integrated urgent care team also having social care colleagues as part of it.

**Health promotion**

The health and well-being of patients was promoted and there was information available to assist with this.

Within the main reception area, there was information available on recognising kidney disease, what the kidneys do and how to reduce the risks of getting it, as well as information on hand hygiene and the use of hand gels and hand washing to prevent the spread of infection.

There were activity staff employed by the council who came to each floor for 90 minutes per day and they offered exercises with balls, yoga and dance as well as singing along to songs.

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

The health and well-being of patients was promoted and there was information available to assist with this.

The service provided mandatory training to staff which included Mental Capacity Act and Deprivation of Liberty Safeguards training. Staff we spoke with could describe their responsibilities under the Mental Capacity Act and where they could access additional advice and support if they felt a patient lacked capacity to consent to care and treatment. We found that the mental capacity assessments completed on the unit were very good.

On review of the records we found very good documentation and understanding of the mental capacity act and thorough evidence of assessment of competence and evidence if there was a deprivation of liberty safeguard (DoLS) in place, although it had been difficult to review some records, as information was not always in one place.

Staff worked together as a multi-disciplinary team to assist patients with understanding their needs and supporting with decision making. The trust set a target of 80% for completion of
mental capacity act training.

From December 2017 to December 2018, the trust reported that mental capacity act level 2 training was completed by 74.4% of all staff in community inpatients services compared to the trust target of 80%.

A breakdown of compliance for mental capacity act level 2 training from December 2017 to December 2018 for all staff in community inpatients services is shown below (however it must be noted that the qualified nursing staff in the figures below included health visitors, but health visitors did not work on this unit):

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified allied health professional staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>25</td>
<td>34</td>
<td>73.5%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request - Training tab)

Deprivation of Liberty Safeguards

During inspection, we saw evidence of good mental capacity assessments with thorough documentation, however we did find that there was one patient who was subject to a deprivation of liberty safeguard who had an out of date extension, although the safeguarding team kept applying for updates to the local authority. Deprivation of liberty safeguards was on the risk register due to the delays in reviewing them.

From December 2017 to November 2018 the trust reported that 206 standard and 207 urgent Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. Of these, 31 standard and 32 urgent applications were pertinent to community inpatients services.

(Source: Universal Routine Provider Information Request (RPIR) – DoLS tab)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff, to meet the needs of the patients and their families and feedback from people who used the service was positive about how much the staff would do for patients, often remarking that “they couldn’t do enough to help”.

During inspection, we observed all staff members speaking to patients and their relatives and carers with compassion and we observed sensitivity being shown during conversations about patient progress and patient needs and fears.

In all areas of the unit that we visited, staff greeted us and all other visitors to the department in a friendly way and we found all staff members regardless of grade or seniority, to be very helpful and accommodating.

We saw a supply of toiletries, such as soap, toothpaste and toothbrushes which were used when patients needed personal care but had no supplies of their own.

As each patient had their own room, it was easier to promote and protect privacy and dignity. Every staff member knew that if the door was shut, that they were to knock first before entering, in case personal care was being delivered and this was highly respected by each staff member. It also allowed for private conversations between staff and patients and patients and relatives and carers. Patients we spoke to told us their privacy and dignity had been maintained.

There were feedback cards available on the unit with a box to put them in, encouraging patients, relatives and visitors to offer comments, or suggestions. There were also statistics on the board from the friends and family test, which showed that for February 2019, with 26% patients extremely likely to recommend the unit and 53.3% likely to.

PLACE self-assessments are undertaken by teams of NHS and private/independent health care providers and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2018 PLACE score for privacy, dignity and wellbeing at the trust was 82.0%.

At site level, the trust scored better than the England average for small acute trusts at the Stamford Unit but like the England average at Tameside General Hospital.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Privacy, Dignity and Wellbeing %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tameside General Hospital</td>
<td>80.3%</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>94.6%</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>Trust average</td>
<td>82.0%</td>
</tr>
<tr>
<td>England Average (NHS small acute trusts)</td>
<td>80.1%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. We saw and heard staff members offering encouragement to patients in a reassuring manner, to alleviate anxiety.

Staff showed an awareness of the emotional impact of conditions on patients and responded with sensitivity. We saw one patient become very distressed, but immediately a senior staff member responded to the patient, lowering herself to the eye level of the patient and offering reassurance. Later, we then heard some staff members discussing what else they could do to help alleviate the patient’s anxiety, considering a request for one of the befrienders to come to spend time with her.

Patients we spoke to told us that staff would often ask if they were okay and if they needed anything and one patient said she felt secure, reassured and comfortable after the staff had assisted her to get ready for bed.

We were told that patients with dementia and part of Johns’ campaign could have family members to stay with them at meal times to assist and reassure them. This would enable the patient who could be extremely confused, to have a familiar person with them, minimising anxiety and distress.

We were told that there was chaplaincy support for those who wanted this, with varying religious denominations and beliefs. There was also the presence of a religious sister on a Sunday.

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

Staff tried to ensure that patients and those close to them were partners in decisions about their care and treatment.

Patients we spoke to said that they understood what was happening to them and their plan of care. Most of the relatives, carers we spoke to said they knew what the plan of care was for the patient, however one relative said they were unaware of what the plan for their partner was.

We were told that the unit were trying to start a carers support group once a month, to offer support and advice to each other, although this was not in place at the time of our visit.

Any national events, such as remembrance-day and the royal wedding were celebrated on the unit and the hub area was decorated accordingly, encouraging patients and their family members/carers and staff to celebrate together. Carnations were worn for the royal wedding and at the last remembrance-day, one of the staff members had made a wreath and there had been a gathering whilst this was laid in the garden area by one of the patients.

Within the unit, there were cards received from family and friends expressing thanks and gratitude for the care that had been delivered and we also saw detail of friends and family feedback. Some of the things people had written included: - “You really are a credit to your professions” and gratitude for giving a family peace of mind when referring to the care that had been given.
Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided services in a way that met the needs of local people.

The Stamford Unit was located on the hospital site, within easy reach of the motorways and with clear signage. There was ample car parking space across different car parks, with clearly marked areas for disabled parking. The hospital was also accessible by different bus routes. The unit had a large welcoming reception area and a waiting area with seats, books to read and vending machines.

On entering the building, there was a large reception area, where visitors were welcomed and asked to sign in. If people needed to wait for any reason, there was a very comfortable seating area with shelves full of books to read. The environment was welcoming bright and airy. We were told that family members could also use the reading area to relax or for ‘time out’ from the unit if required.

The ground floor ward of the unit was accessible via locked doors, but there were lifts or stairs for people to access the other two floors of the unit, with either wheelchairs, push-chairs, or for those with restricted mobility. The unit itself was very modern and airy and all the staff wore name badges identifying their name and role.

There were 32 rooms on each floor, each with its own en-suite bathroom, which comprised of a toilet, sink and wet room shower, all with disabled access. Each bedroom door had a lock. On asking, we were told that it was rare for someone to lock themselves in their rooms, but in the event of this arising, each qualified staff member had a master key to all the bedrooms. There were other toilets available for use and a large bathroom which had a jacuzzi bath for patients to enjoy should they choose to.

There was a large garden area outside of the unit and we were told that patients had been involved with some of the planting that had been done, following donations from a local hardware company.

The service provided a 24-hour service for intermediate care delivered to the local population. It worked closely with the acute part of the hospital, social care, community services and local authorities to build on specific knowledge and to improve services delivered.

Services were planned with the needs of local people in mind, as most of the patients within the unit were from nearby areas, which allowed their family and friends to be able to visit more easily.

Patients had their own individual rooms, which gave them a bed space, seating area with table, wardrobe and storage for belongings, as well as their own wet-room style en-suite bathroom, enabling them to have their own personal space and privacy.

The service worked closely with digital health, which allowed them to be able to offer medical reviews of patients via a digital method, reducing the time needed for a review. This was particularly useful if a patient needed a review after a fall.
The unit had designed a transfer pack, based around the situation, background, assessment and recommendation method, which was to be used when a patient transferred out of the service. This care model was designed to improve the effectiveness of transfer of patients.

The trust was asked to list ward moves for a non-clinical reason during the last 12 months.

The trust reported no ward moves within community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal – Ward moves tab)

The trust was asked to list ward moves between 10pm and 8am for each core service for the most recent 12 months.

From November 2017 to October 2018, the trust reported that there were ten moves at night for community inpatients services. An audit of the 10 identified patients had been undertaken. This identified some data quality issues, suggesting that not all moves took place at these times. The division had taken steps since that time to address data quality issues and that it had been confirmed by a further audit undertaken for the period from November 2018 to the present day. The audit suggested that only three moves in total had occurred between floors, two of which were during the day, with one confirmed as being to ensure a husband and wife could be accommodated together.

(Source: Universal Routine Provider Information Request (RPIR) Universal – Moves at night tab)

The trust reported no mixed sex breaches within community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – Mixed sex tab)

**Meeting the needs of people in vulnerable circumstances**

The service took account of patients’ individual needs.

The admission process to the unit used a paper-based referral system, completed by the referring ward/unit. This was then submitted to the integrated urgent care team (IUCT) who would then ensure the patient met the criteria for admission. The team would sometimes undertake a face-to-face assessment of the patient dependent on the information provided. The referral would then be received by the senior nursing team on the unit, who would review the referral regarding the level of the dependency and complexity of the patients already admitted to all three floors of the unit. This would include reviewing how many patients on the unit were prone to falls, or who needed regular turning for pressure relief, or consideration of any patients who may need additional support with nutrition and hydration, particularly if requiring special feeds. The review of suitability of patients also included the consideration of patients who might be confused or be subject to a deprivation of liberty safeguards.

All the corridors, bays, cubicles and bathrooms were wide, making it accessible for wheelchair users and hoists. There was also an assisted bathroom, allowing patients to have a jacuzzi bath if desired, with ample space for the use of a hoist if required.
The unit had room that had been designed for bariatric patients; this had ample space for any equipment like wheel chairs and hoists that might be needed, whilst also being able to easily accommodate visitors. This room also had doors out onto the garden area.

There were lovely garden areas to the unit and we were told that a local hardware company had donated many of the plants and pots, which some of the patients had then potted with support from staff. This had also acted as therapy for helping to improve their co-ordination and movement. There was also a statue cow in the garden to offer some visual stimulation. We also saw a hand-crafted remembrance area, which we were told had been made by a staff member, with a patient placing a wreath down on remembrance-day.

There was a service level agreement in place with Active Tameside. This service provided staff to deliver activities for the patients on the unit. They came four days of the week and offered activities on each floor for 45 minutes on each of the four days. Activities included singing, yoga, dancing, bingo and ball work. We saw this during inspection and it always gathered a large group of patients, who clearly looked to be enjoying themselves, as it promoted physical and mental activity, as well as encouraging communication with other patients. However, we did not see patients being engaged in many other activities when this was not available, although staff did tell us of upcoming events they were planning for, such as a garden party.

Patients had supervised access to the gymnasium in the unit, where we saw aids, including stairs to encourage mobilisation and reablement. Therapists told us that they would like to see the introduction of more groups, such as a balance group, once more staff were in place. The unit was dementia friendly and there was a small team of admiral nurses within the building. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. The team would also support the staff on the unit, offering specialist training and advice as required. We were also told about an interactive table that offered interactive games, stimulating both physical and cognitive activity and encouraging social interaction. Equipment for distraction purposes was also available for use if required. The unit also had a reminiscence box which contained old-fashioned games and books and other memorabilia.

A hub area was the main central point of each floor and this was used for patients who needed more supervision, as this was in front of the reception area and nurse’s room. It had comfy seats and a large television, as well as a piano and different games. Staff told us that there were other activities available for patients to engage in, including croquet, ‘knit and natter’ and the team were planning a garden party. There had also been a movie night, which we were told one of the health care assistants had arranged and led.

The unit had a volunteering service that was available until 6pm. We saw a patient who was distressed and frightened as they were new to the unit and we heard staff members saying that they would ask the volunteer to come and spend some time with the patient to help relieve some anxiety.

For patients with learning difficulties, or other patients with difficulty in communicating, there was an availability of pictorial aids to be used to aid communication. The unit also had access to complex care nurses for advice or support as needed. There was information in the new records template for patient assessment that had a section entitled ‘Getting to know me’ to ensure that invaluable detail and patient preferences were captured and recorded so that all staff involved in the care and treatment of that patient were aware.
There was access to the language service for those whose first language was not English and there was also access to people who could use sign language if required. Access to a hearing loop was also available for those hard of hearing.

Camp beds and reclining chairs available for people to stay with their loved ones if needed and we were also told that the admiral nurses were also buying an additional three camp beds.

**Access to the right care at the right time**

Patients could access the right care at the right time. Waiting times were minimal and managed in a manner that met patients’ needs.

Referrals for the unit came via the integrated urgent care team, who reviewed them and assessed the level of care needed. There was an admission-criteria for the unit, which was adhered to. The integrated urgent care team liaised with the senior staff from the Stamford Unit to assess the acuity of the patients on all three floors of the unit, in relation to maintaining patient safety, before an admission were accepted.

The service worked closely with community services to provide integrated pathways for patients and to coordinate care and treatment for patients moving out of the service and back into community services.

The ‘length of stay summit’ meeting every week had made a large impact on the length of stay people were in for and had halved this time over the last year. Patients who had been on the unit over seven days were discussed as part of the meeting and care and treatment reviewed in terms of therapeutic goals and barriers to discharge. We were told that there was also a ‘home finder’ who helped patients going through a choice process with where to live.

At the ‘length of stay meeting’, we were told about some funding for transitional beds over the winter months, which was available until the end of April 2019, offering one nursing and two residential beds, which had also really helped with flow throughout the unit.

At the time of inspection, we were told of six patients on the waiting list for admission and on one of the days we were there, there had been 15 discharges. We were not told about specific waiting times for admission to the unit.

Bed meetings were held five times a day, with three of those being dial-in meetings. The purpose of the meetings was to review how busy the unit was and to try and prioritise surgical patients when able to do so.

We requested information on readmission rates to acute care and reasons for this. We received the rates as detailed below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Discharges home from Stamford Unit</th>
<th>Readmissions to acute within 28 days</th>
<th>Readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2018</td>
<td>96</td>
<td>11</td>
<td>11.5%</td>
</tr>
<tr>
<td>January 2019</td>
<td>116</td>
<td>25</td>
<td>21.6%</td>
</tr>
<tr>
<td>February 2019</td>
<td>85</td>
<td>14</td>
<td>16.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>297</strong></td>
<td><strong>50</strong></td>
<td><strong>16.8%</strong></td>
</tr>
</tbody>
</table>

The main reason for re-admission (10 of the total) was for pneumonia, with the organism unspecified.
The trust provided the following data on the largest Black and Minority Ethnic (BME) groups within the trust catchment area of Tameside. The largest ethnic minority group within the Tameside area is White Europeans with 2.4% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Europeans</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian British: Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian British Bangladeshi</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian British: Indian</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – Accessibility tab)

The trust provided information regarding average bed occupancies from November 2017 to October 2018.

A breakdown of bed occupancy levels for community inpatients services as of October 2018 is below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Ward</th>
<th>Average bed occupancy in October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit Ground Floor (opened June 2018)</td>
<td>94.6%</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit 1st Floor</td>
<td>94.1%</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit 2nd Floor</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

(Source: Community Routine Provider Information Request (RPIR) – Bed occ & LOS)

The trust provided information for average length of stay from November 2017 to October 2018.

A breakdown of average length of stay for community inpatients services as of October 2018 is below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Ward</th>
<th>Average length of stay (days) in October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit Ground Floor (opened June 2018)</td>
<td>20</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit 1st Floor</td>
<td>22</td>
</tr>
<tr>
<td>Stamford Unit</td>
<td>Stamford Unit 2nd Floor</td>
<td>20</td>
</tr>
</tbody>
</table>

(Source: Community Routine Provider Information Request (RPIR) Community– Bed occ & LOS)
Referrals

The trust did not report any data on referrals for community inpatients services.  
(Source: CHS Routine Provider Information Request – Referrals tab)

Delayed discharges

From November 2017 to October 2018, there were 314 delayed discharged in community inpatients services. This amounts to 30.3% of the total discharges in this core service.

Delayed discharge trends from November 2017 to October 2018 at Tameside and Glossop integrated Care NHS Foundation Trust

![Graph showing delayed discharges from November 2017 to October 2018](source)

(Source: Universal Routine Provider Information Request (RPIR) Universal – DTOC tab)

Learning from complaints and concerns

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

Within the trust, there was a Patient Advice and Liaison Service to provide support to patients, carers and families. Once a complaint was received, there was a complaints team who reviewed and triaged the complaint. If the complaint was formal, there would be a formal response written by a senior staff member from the unit and this would then be reviewed by the Chief Executive Officer and sent out accordingly.

Staff knew where to access the complaints policy on the trust intranet and could tell us how to help a patient who wished to raise concerns.

During inspection, we looked at three formal complaints and the actions and lessons learned with a senior leader. We could see that the complaints had been taken seriously, responded to in an appropriate way and that themes had been taken from the issues that had arisen and some new developments made on the back of the complaints to improve services. Some of the examples
we saw included the development of a property checklist, detailed information leaflets to be given to patients in the acute setting to explain the service that would be offered at the unit and the development of an electronic template that was to be multi-disciplinary to improve information obtained about the patient, the method of collecting this information and the communication of this between staff, whilst also improving the speed that the take home medications would be arranged prior to discharge.

We had sight of a comments box and comment cards that were readily available in the main corridor of the unit for patients, relatives and friends to complete if they wanted to.

**Summary of complaints**

From December 2017 to November 2018 the trust received 11 complaints in relation to community inpatients services (2.5% of total complaints received by the trust). The most frequent subject of complaints was patient care (four).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>4</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

For the nine complaints that had been closed at the time of data submission, the trust took an average of 25.3 working days to investigate and close these. This is in line with their complaints policy, which states complaints should be closed within 45 working days.

The two complaints that had not yet been closed had been open for an average of 42.0 working days at the time of data submission.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

We saw that a new staff member had received a compliment on our first day of inspection, having only been in post for two weeks. The staff member was part of a pilot as a joint ward clerk and care co-ordinator to look at reducing the length of stay and to increase more morning discharges and the compliment had been received from one of the district nurses.

From November 2017 to October 2018 there were 218 compliments received for community inpatients services (1.6% of all received trust wide).

Compliments were received in all 12 months of the period. December 2017 was the month where the most compliments were received (52).
The trust reported it has been identified that areas of the trust which experience a greater volume of patient attendances, such as the Emergency Department and Day Surgery Endoscopy Unit also receive the highest volume of positive comments. This is consistent with the high numbers of compliments reported by these departments directly.

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The Stamford Unit came under the division of intermediate tier services, which was one of the three divisions that reported up to the trust board. Overseeing the unit, there was a unit manager, matron, assistant director of integrated rehabilitation and therapy services and the service director for intermediate tier services, who was also the lead nurse. All the leaders we met had the experience, capacity, capability and integrity to make sure that a quality service was delivered and risks to performance were addressed.

The matron for the unit was very experienced so had good insight into the management needs of the unit. The unit manager was dynamic and they both worked in partnership with the lead nurse who was enthusiastic and innovative. All the staff we met with told us that service leaders were seen to be visible on the unit and they had a good understanding of frontline challenges.

The therapies team was managed by a physiotherapist on secondment, but there were plans in place to make a permanent appointment to the post. One of the therapists we spoke to said they had been managed well by senior leaders overseeing the therapists’ team since they had come to the unit and they reported their senior management to be very visible and supportive.

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 Tameside and Glossop Integrated Care NHS Foundation Trust vision was to improve health outcomes for their population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and their health and care partners. There were also various strategic plans which fed into the trust strategic plan, ‘2017 – 2022 Beyond Patient Care to Population Health and Clinical Services Strategy.’

On speaking with the leads for the Stamford Unit, we were told that their vision was preventative care, involving the right people for the right patient at the right time and that this required engagement with the right people, to ensure patients received a seamless transfer from the hospital to the unit. Senior leaders told us that although the unit accepted ‘step-ups’ from the Accident and Emergency department, they also wanted to start taking ‘step-ups’ from people’s homes using the General Practitioners (GPs), being supported by digital health, the on-call doctor service and nurse practitioners, whilst also valuing the importance of third sector organisations in improving patient health and quality of lives.

We were told that objectives from the wider strategic objectives fed into the staff appraisals.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose, based on shared values.
Staff described the culture within the service as open and positive, with leaders being easily accessible and supportive.

All the staff we spoke with regardless of role, were open, honest and very helpful.

In June 2018, there were a lot of staff that came from another unit which had been closed and so they were subsequently moved to one of the floors within the Stamford Unit. During the inspection, we held some focus groups to allow staff members to speak openly to us about anything they wanted to mention. Staff openly told us that it had been a difficult time when they had first moved over, as each group of staff members had their own way of working, so initially the integration of a collaborative way of working had been difficult and had caused some unrest and some staff were unhappy at the time. However, staff went on to explain that although it had been a difficult time, the teams had worked through this and staff would now work on different floors within the unit and there was more of a happy culture and sense of unity. Staff told us that nobody would ever say “no” to anyone and there was such an improved sense of teamwork and communication.

The unit supported learners of different disciplines and one of the students we spoke to told us that they had been immediately welcomed onto the unit and instantly made to feel part of the team.

All the staff we spoke to told us that all staff, regardless of role, were encouraged to voice their opinions and ask questions, whilst feeling supported to do so. On asking staff about awareness of any ‘Freedom to Speak up Guardians’ or champions, the response was mixed, with some staff aware of a champion to contact, whilst newer staff members were not as confident of who to contact.

We did not see or hear of any evidence of harassment or bullying during inspection.

**Governance**

The trust used a systematic approach to continually improve the quality of its services.

The board and other levels of governance in the organisation functioned effectively. Governance arrangements were clearly set out, understood and effective. There was a clear governance structure and staff members were clear about their roles and accountabilities and promoted a quality service that met patient needs.

All staff completed a yearly appraisal, which was reviewed by their manager. Therapy staff also had monthly performance meeting with their manager to review all aspects of governance. Managers had sight of all staff members which were approaching training deadlines and this was reviewed also monthly.

The service completed several audits within the unit to monitor compliance, some of which included record keeping and hand-washing audits.

Within the intermediate tier services, staff were clear about their roles, what they were accountable for, and to whom they were accountable to.

Each service had its own action plans. We were told that when the number of falls were not reducing in line with the action plan, the service began to look at the times of falls. There was also a falls scrutiny panel who reviewed this and consequently January/February saw a reduction in the number of falls.

The unit partook in monthly continuous improvement meetings to monitor and improve standards across the unit. Senior leaders from the unit attended divisional Quality and Safety meetings, to
represent the unit. Staff told us about the service, quality, operational governance group (SQOGG) which was a sub-group of the trust quality and safety committee, which was also a sub-committee of the board. The Director of intermediate tier services attended this as a representative of the intermediate tier services. We saw minutes of the meeting which took place in February 2019 and saw that divisional updates were given, which included the Stamford Unit.

Several staff members we spoke to reported an improvement with a lot of formal processes, especially since there had been some changes in senior management.

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.

The service had a process to identify, understand, monitor and address risks. Risks were monitored and reviewed to maintain a high quality of care to patients and were fully understood by staff.

On asking senior leaders what they considered to be risks for the service, we were told that falls, staffing and the authorisation of deprivation of liberty safeguards that had expired were on their risk register.

Senior leaders were aware of risks and performance issues within their own area and had addressed key risk areas.

To minimise patient safety risks on the unit, bed meetings were held several times a day, to review risks and to ensure that all staff on duty were aware of any changes in risk to the patients on the unit.

The unit stood separately to the acute hospital, but it had front doors which opened into a reception area. There were doors which led to a separate corridor and these were locked by key pad entry. On the other side of the doors, there were more doors into the unit which were locked again by key pad. This was the same for the entry to each floor of the unit, so although the building was separate, it was secure entry.

The trust had an incident response plan, written by the trust fire safety manager. The plan was dated 2017, although it did not contain a review date. The plan described different types of incidents, including business continuity, critical and major incidents and how these should be managed effectively.

Information management

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

Information systems supported quality patient care and treatment. Information was shared widely in the organisation promoting improvements. Information was kept securely and maintained the confidentiality of patients.

The unit engaged regularly with digital-health on and there was an electronic tablet to use during patient reviews. The staff told us that the use of digital-health was very effective and offered timely assessments of patients.
The trusts policies and procedures were easily accessible for all staff members via the intranet. We also saw clearly labelled and well-organised folders on the shelves in offices on each floor, which contained useful information for staff to access, such as a safeguarding folder.

There were computer stations with intranet and internet access available throughout the service and there were enough numbers of computers for staff to access information.

We saw there were quality information boards on the unit which provided current quality data such as staffing levels and safety performance.

There were clear notice boards on the main corridors of the unit detailing patient and relative/carer feedback. We also saw a large display of thank-you cards available for others to read.

## Engagement

The trust engaged well with staff to plan and manage appropriate services and collaborated with partner organisations effectively.

We were told that there was a strong staff engagement strategy, some of which had been developed for staff by staff.

Senior leaders told us about plans in place to engage more with staff and talked about the upskilling of both the physiotherapy and occupational therapy instructors and assistants, to develop their skills as practitioners, but to also enable the therapy service to run over seven days, instead of five. We were also told about plans for staff representatives of varying grades to be involved in advising what they thought would make their working life better, with mention of working alongside someone else to see what they do, to offer a better understanding of other people’s roles.

The division that the unit came under had also engaged in a cultural barometer survey and out of 500 staff in the division, 85 had replied. Leaders had an action plan in place to use the feedback in a productive way to improve on areas highlighted by the survey.

There were also patient and inpatient awards to recognise staff who had gone above and beyond either for their patients or for their colleagues.

We also learnt that there had been an allied health professional day held in October 2018 and it had been agreed that this would be a regular event.

The lead nurse had also delivered some showcase events for the intermediate tier services, which took place in December 2018, with an evening meal being provided. There were presentations including the identification of top divisional risks, service developments and good things that were happening within the services.

The unit tried to ensure staff were updated on any news or changes, some of which was done by means of a communications newsletter, social media and performance boards.

## Learning, continuous improvement and innovation

There was a positive focus on continuous learning and improvement for all staff. Staff members said they were supported to develop their professional skills and encouraged to shared good practice and identify innovation.
The unit manager told us that there was her and another senior staff nurse who would be studying together to complete an apprenticeship in management, which was supported by senior leaders within the unit.

Within the service, there was a culture of supportiveness and learning. It appeared evident that the service learnt from mistakes and continued to strive to be the best they could be.

One therapy staff member had created an allied health professional forum to look at different areas, ranging from recruitment, talent management and future planning. All allied health professionals and the chief nurse had been invited to attend.

The service engaged in continuous improvement meetings and on reviewing the minutes from these meetings, we could see that there were regular discussions around the unit’s ‘continuous journey’. There were discussions around ‘our continuous improvement journey’ presentations, which were drafted by staff.